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ABSTRACT

This booklet was prepared to disseminate knowledge of the British National Health System to provide for improved cooperation between clinicians, health scientists, and health administrators in the United States and the United Kingdom. Included are chapters on: (1) the evolution of the British National Health system; (2) its present status; (3) general practices; (4) the relationship between welfare services and health services; (5) consumer interests; (6) community medicine; (7) health planning; (8) allocations of resources; (9) professional autonomy; and (10) manpower policies. (SL)

THE BRITISH NATIONAL HEALTH SERVICE

Conversations with Sir George Godber

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Conversations with Sir George E. Godber

A Publication of the
Geographic Health Studies Program
John E. Fogarty International Center
for Advanced Study in the Health Sciences

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PREFACE

The worldwide eradication of disease is a declared major goal of United States health efforts, and aid to all nations toward the elimination of hunger and sickness is an aim that has been officially enunciated on several occasions. Much progress in these directions has and is being made, and the John E. Fogarty International Center for Advanced Study in the Health Sciences is playing a part in this progress.

Established as part of the National Institutes of Health in July 1968, and named in memory of the late Congressman John E. Fogarty of Rhode Island, the Center is an organization envisioned by Mr. Fogarty and called for in his address to the Third National Conference on World Health in September 1963, as "a great international center for research in biology and medicine dedicated to international cooperation and collaboration in the interests of the health of mankind."

The Center serves as the communications pulse for scientific information emanating from abroad and provides American and foreign scientists opportunities to deal with complex problems of vital concern to mankind's well-being. These opportunities and services are inherent in the Center's International Education Program, in its International Fellowship Program, the Visiting Program for Foreign Scientists and the International Research Exchange Program which enables American health professionals to study abroad.

Many and varied health-related topics have been investigated by the Center's Scholars-in-Residence Program, by a continuing program of conferences and seminars, and by its 6-year-old Geographic Health Studies Program. This latter enterprise has undertaken a series of studies designed to obtain and disseminate comparative knowledge of the health care systems of other countries.

This document is the third in a series of studies which examines the British National Health System, which was developed around an advanced medical-scientific capability. It represents an alternative approach to a health delivery system, relying significantly upon regional and local authorities to plan and provide the service. Studies of this health system will therefore permit access to knowledge and experience beneficial to other countries seeking to provide the most efficient health care for its people. Additionally, it is hoped that knowledge of medicine in the United Kingdom will provide a basis for improved cooperation between clinicians, health scientists and health administrators in the United States and the United Kingdom.

The principal discussant of this document, Sir George E. Godber, conducted "Conversations" during his appointment as a Scholar-in-Residence at the Fogarty International Center. As a former Chief Medical Officer of the Department of Health and Social Security, Sir George Godber is eminently qualified to discuss the various aspects of the National Health Service. He brings an international perspective to his observations since he has visited most of the countries of Europe and is acquainted with patterns of organization of health services in these countries and in North and South America and Australia.

Inquiries about this and other publications of the Geographic Health Studies Program, which are listed elsewhere in this book, should be directed to Dr. Joseph R. Quinn, Geographic Health Studies Program, Fogarty International Center, National Institutes of Health, Bethesda, Maryland 20014.

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THE EVOLUTION OF THE NATIONAL HEALTH SERVICE

DR. MILO D. LEAVITT It is a great pleasure for me to introduce our speaker this afternoon, Sir George Godber. Like many members of the international community, I have known Dr. Godber for many years, both in Her Majesty's Service as concerned with the National Health Service of Great Britain, and during his attendance at many World Health assemblies, and for his contributions to the World Health Organization itself.

Before his retirement from government service, he was Chief Medical Officer of the British Department of Health and Social Security. Since retiring he has been very much in demand by audiences here and abroad and his services have been sought for a variety of international activities.

With his talk this afternoon, which we would like to be very informal, Sir George introduces a new Fogarty Center series, a British Health Series, which is a component of the Center's Geographic Health Studies Program. In view of the attention being given in the United States to the development of national health insurance, and to the ultimate possibility of a national health service, this afternoon's topic, The Evolution of the National Health Service, should be particularly interesting.

SIR GEORGE GODBER: Thank you very much. I need hardly say that I am very glad to be here and most proud to have been invited to come here as a Fogarty Scholar. I have been in this room and in this building a good many times before at meetings, but now I have to try and convince myself and you that bringing me here has really been worth the effort on the Fogarty Center's part.

I am scheduled to do ten sessions on this subject, and during this initial meeting it is my intention to talk not so much about what the British National Health Service is doing now, as how it evolved, going a long way back. My reason for doing this is that I believe there are illusions among the professions and the public that you can suddenly, as it were, go to the legislature one day and say, "Let us have a health service." And they will say, "Oh, good idea. So be it." And the next day you introduce a health service, something you didn't have before. Well, nothing could be further from the truth. Of course, a health service builds up, as we all know, over many, many years but what we had in Britain on July 5, 1948—which was the first day of the National Health Service—was just what we had had on July 4, but we paid for it differently. That is really what happens on your appointed day.

Once, about a year after the British National Health Service's beginning, I was speaking to a group of students in Cambridge. They included some people who were clearly hostile and one who was equally clearly the son of a disenchanted established doctor. The latter posed a long rhetorical question, ending up with "Why July 5?" To which I replied, "It was the middle Monday in the year, and that is as good a reason as I know for starting anything, if you cannot take the first of the year."

What I am saying is that the evolution of health services in any country, and in Britain the same as anywhere else, depends a great deal upon the pattern of organization of society, both central and local. It has to be local as well as central, it is an illusion to believe that personal health care can be organized from a government department. This is impossible – the best contribution that a government department can make is to provide satisfactory local agencies in support of the provision of health care. Other factors influencing the way it is done are the structure, the distribution and the influence of the medical profession – and those, of course, change over the years. So that the way health service negotiations might have started with the medical profession in Sweden, where there was a rather different relationship with government, was quite different from the method of starting in Britain. Then there are also the changing needs and capabilities of the protagonists of health care, changing health needs because the techniques of health have enabled dealing with communicable disease. Thus there suddenly are problems that are not new, but problems for which there previously had not been time or aptitude, such as chronic and degenerative illnesses and the burdens they put on people.

Of course, the new developments of pharmacology and the pharmaceutical industry contribute very largely to what can be done by providing vaccines and drugs that really do something. Whereas, for example, 50 years ago we had quinine and thyroid extract, we did not have insulin, we had the alkalis for some urinary infections and we had aspirin, but what else was there? Even the arsenicals for treatment of syphilis, for instance, were rather risky to use and not wholly effective.

Therefore, the stage we have reached in the technical development of health is going to make a considerable difference to the urgency with which we face the need to provide for it. There is also the public perception of the need for protection and care. At the beginning of this century people were taking what came with a great deal less expectation from the medical profession than they would today. After all, people such as Hippocrates or Democedes perhaps opined about certain disease eventualities, and doctors at the middle of the nineteenth century hadn't progressed much further, and maybe weren't even as accurate. But now the public knows that medicine can do a great deal, expects much more from it, and requires to have it explained.

There are also precipitating factors for change, like financial stringency, which necessitates a search for the simplest, most economical way of providing services. Industrial changes, too, lead to movement of population and precipitate the need to provide organized health services; and a major war will completely change the outlook of a group of people who have experienced an organized health service, perhaps in the forces of their country, during wartime.

In the USSR, or in other countries which have faced revolution, a social revolution leads to an immediate decision to introduce something organized for the care of health. And all those things, except revolution, came together in Britain in the period 1946–48. But I go back to recapitulate a little of what was happening earlier, before that.

In the nineteenth century in Britain personal health care was regarded as being wholly the responsibility of the individual. But groups began to organize, among the poorer people at least, in order to provide some sort of prepayment insurance. This was done on a much more extensive scale in other European

countries, particularly Denmark and Prussia, but in Britain by the end of the century there were large Friendly Societies, as they were called, providing under contract with doctors some kind of medical care, as well as payments during illness, to their members. They drove pretty hard bargains with the doctors with whom they contracted. That, indeed, was one reason why a national organization of insurance-provided service later became necessary. Before that, from 1835 on, there had been the Poor Law system for taking care of indigents and, since the term indigent would sometimes include those who were sick, the Poor Law system had to make some provision for the care of people who were ill.

In this same era came the beginning of concern with the environment which, being conducive to the spread of communicable disease, was the cause of much mortality at that time. From roughly the middle of the nineteenth century, government began to concern itself with improving sanitation, particularly in towns, a concern brought about by the movement of population during the industrial revolution.

There was established in Britain in 1848 a central authority—a central board of health under the Privy Council, in addition to already-established local bodies responsible for health care in towns. The major health legislation of the nineteenth century occurred in 1848 and 1875, and was directed mainly toward control of sanitation and water quality, the clearance of wastes and so on. This legislation was beginning to produce substantial effects on health even before the nature of infection was known. But once the nature of infection began to be understood, communicable disease control began to be undertaken more systemically and the establishment of hospitals for isolating patients suffering from infectious disease—in addition to those already existing for the isolation of smallpox—became general from about the year 1880. Before that time, the principles of isolation were so little understood that in the days when smallpox patients were isolated it was the custom for the drivers of horse-drawn ambulances to stop at public houses on the way to the isolation hospital. The driver would regale himself and the public would look at the unfortunate patient through the back door of the ambulance. This led to the belief that infection escaped from smallpox hospitals, but what really was happening was that no one was taking care of the infection from the patients going into them.

By then, too, the segregation of others thought to be dangerous to the public, such as those who were mentally ill or seriously mentally handicapped, began to be undertaken, usually in large institutions behind high brick walls, out in the countryside. There was little idea of treating the unfortunate patients. But in the middle of the century there was a very rapid growth of the voluntary hospital movement which had led earlier to the establishment of famous teaching hospitals like Guy's and St. Thomas's in the previous century, and St. Bartholomew's as far back as monastic times. This movement spread throughout Britain in the eighteenth century.

Somebody like Benjamin Gooch of Norwich, who was that city's most distinguished doctor at the beginning of the last century, was actually instrumental in collecting the money to build a hospital which—the building—is today still in use as the postgraduate center for the Norfolk-Norwich district. Indeed, I had the privilege of opening it as a postgraduate center when we replaced it with a new hospital building just 2 years ago. But those hospitals

which started as places for nursing the sick poor as opposed to elderly, permanently incapacitated and chronically sick people, began to be used by the medical schools and by the developing specialties in the medical profession in order to provide care for the acutely ill rather than support for the sick poor, i.e., those suffering from acute illness rather than those who necessarily had to stay for a longer time.

At the same time the profession of medicine was getting organized. Physicians and surgeons as specialists had been organized in London, Edinburgh, Glasgow and Dublin for many years before the start of the nineteenth century. But the group from which general practice has mainly come, the apothecaries, although they had been organized from the seventeenth century, began to develop with the establishment of the first qualifying medical examinations in Britain in 1816. The more prestigious Royal College of Surgeons and Physicians in London took another 40 years to follow the progressive example of the general practitioners.

In the latter part of the century the universities and their medical schools, outside London, were developing more rapidly than the hospital-based schools in that city. The London schools (which perhaps are still those with the highest prestige in Britain) today cannot really be said to deserve pre-eminence with the expansion of university-based schools which were established as such before most of the London schools were transferred to universities. Incidentally, the latter event was a by-product of establishment of the National Health Service.

One thing that happend in Britain and which is distinctively different from events in the United States, is that the specialist-general practitioner relationship changed. The internists had fought physically and legally with the apothecaries in earlier centuries and only slowly had come to some sort of division of function between them, with the physicians acting as consultants upon patients referred to them by apothecaries. And apothecaries, who had originally been more druggists than doctors, had become the doctors delivering most medical care in Britain and were distributed over the whole of the country by the end of the nineteenth century. Some nursing schools had been established. Florence Nightingale, for instance, had established the nursing school at St. Thomas's Hospital, and the Queen's Institute of District Nursing had established nursing services which, through voluntary organizations, were available to people in their own home, mainly in rural areas.

Later, in the period 1900-39, personal preventive care began to be organized. At first, this was on a voluntary basis to provide well-baby care and some antenatal care, from about 1900 onwards. This developed slowly up to 1919, at the end of World War I, by which time it had become the responsibility of some of the larger local government agencies. The School Health Service had been established in 1907 because of the findings of unfitness of so many recruits at the time of the South African War, an experience which I believe was later repeated in the United States, at times of recruitment for wars.

In 1905, a Midwives Act established the training and control of midwives who, from then on, took care of an increasing proportion of the deliveries of pregnant women. The Friendly Societies in their contract practices had developed further, but it wasn't until 1911 that a reforming Liberal Government with Lloyd George as its leader in this respect, decided that there

must be a universal health insurance program on behalf, at that time, only of insured workers. Now, that differs from some of the arrangements made by the stronger health insurance organizations in some of the Western European countries, notably the Federal Republic of Germany and Denmark, where dependents of insured workers were brought into the insurance system. However, a British insured worker who was entitled to free medical care and was paid something in lieu of his wages if he was sick, had to make his own arrangements for any care that his family might need. Inevitably, in those circumstances, in the poorer groups the family went short of care.

Traditionally, the medical profession invariably shies away from any kind of organization of its services. And in 1910 and 1911 in Britain it ran true to form, for there were proposals for the wholesale withdrawal of doctors from services in particular areas, and there were even doctors who, because of their known resistance to national health insurance, as late as 1911 found themselves threatened by mobs. Then, again, as always happens when government and the people want to go the right way and the doctors do not, the doctors were finally persuaded to give in by those exhibiting greater good will, and national health insurance was introduced in 1911.

At that time doctors tended to have their own insurance clubs in order to take care of the dependents of insured workers, and this 1911 national insurance had one very interesting by-product—a small part of the contribution made by workers was set aside to support medical research. Before World War I a Medical Research Committee was established using funds from this source, not funds contributed by the government. Also, a small part of this money was set aside for providing what was called sanatorium benefit for the tuberculous, at a time when such sanatorium care was a relatively new development.

World War I sharply increased concern about the health of children, and also increased the demand for intervention by local government. Many of the elected councils of cities and counties had not used their powers to provide antenatal and well-baby care, and it was not until a parliamentary Act in 1920 placed a duty on them to provide such services, that people in all parts of the country began to benefit.

Later, in 1920, the Ministry of Health was established. (I will be relating more about this on a later occasion.) The Ministry brought together most of the health functions of government and acted as a supervisory body over local authorities responsible for providing health care, and over local committees responsible for administering national health insurance. Thus, the central government's activities in health areas, which previously had been conducted as a relatively minor activity of the Local Government Board, now became the major concern of the Ministry—a full-scale government department. Other professions were also beginning to be organized at this time; nurse registration dates from 1920 and the registration of dentists from 1921.

From then on the development of organized health facilities progressed much more rapidly. Increased health responsibilities were given to larger elected city and county local authorities, which, unlike those in Sweden, New Zealand or Denmark, had other large local government responsibilities. So, although these British authorities had increasing health responsibilities to discharge, using locally-raised tax funds, they had other even larger responsibilities such as education, the provision of roads and control of the environment, and these took up more of their concern than did the health

responsibilities. They were later to inherit, in 1929, the responsibility for operating the Poor Law, which since Elizabethan times had been running as a local means of taking care of the indigent, and which by this time had a large health component; indeed, it probably had more nonpsychiatric hospital beds than did the nation's other hospital authorities altogether.

In 1929 and in 1933 legislation consolidated the responsibilities of locally-elected governments and gave them power to put all institutional health care under their health organizations (rather than their welfare systems). That was a significant change because locally it was bringing together the various components of health service.

Throughout this period, the voluntary hospitals had continued to grow, but they had also continued to be increasingly selective in the patients for whom they cared. Originally set up to house the sick poor, they had become places where doctors with specialized training were providing care for acutely-ill patients who stayed in hospitals for relatively short periods. Just as general practice and specialist practice had been separated outside hospitals—so that the specialists saw only patients referred to them by general practitioners—the staff posts in hospitals where specialist work was performed also came to be available only to selected people, people selected for their specialized qualifications. Physicians in good standing in the area did not have admitting privileges, unless selected, save to small cottage hospitals in rural areas.

But in the 1930's medical discussion of a health service for the nation was becoming commonplace. A report by Lord Dawson, which was the result of a committee's work in the early 1920's, was very widely read in Britain and elsewhere. This suggested a regional basis for providing health care. Discussion in the medical profession, about the desirability of providing a health service, mainly centered on questions such as whether or not it should cover all the people. (The service in Denmark, for instance, until quite recently differentiated in its provisions according to income level.) But, of course, hospital services and general practitioner services had been developing continuously, all this time, whatever administrative discussions there might have been, and one thing that national health insurance had made certain was that there would be a doctor within reasonable physical distance of every member of the population. Today, there is hardly anyone in Britain who has to go 10 miles to reach a doctor. While there may be a few isolated people in the Highlands of Scotland or in Wales, in England this situation is most unlikely.

The preoccupation of the period of World War II, 1939 to 1945, was with war requirements, and war requirements in Britain meant dealing with armed forces casualties and civilian casualties on a very considerable scale. Populations were moved from the cities likely to be exposed to bombing, and it was necessary to provide them with health care in the rural areas in which they were billeted. In the first weekend of the War 2 million people went out of the cities into the countryside, and this, in a population of about 40 million, meant a considerable shift in the burden of work. It also was necessary to provide hospital accommodation outside the main cities because of the risk of air attack on city hospitals. Required was an ambulance service to cover the whole population, a service that had not previously existed, and since many civilian doctors necessarily were inducted into the services' medical corps, civilian health services were medically depleted.

During the war, one of my jobs was to provide on very short notice maternity homes for women in advanced pregnancy who were evacuated from London, the south coast, and Sheffield, and one or two other areas likely to be attacked. In this way maternity hospital facilities were brought to countryside populations who had not previously had them. These things had to be done on a regional basis, and there was a Ministry of Health regional organization which in effect organized the strategic use of the hospitals in war. The large voluntary hospitals were dependent predominantly on financial support from the government, at least for most maintenance expenditures (there was no hospital building going on at that time). It was at that time realized that British hospitals needed radical reorganization and, even in the war years 1943 to 1945, it was decided to survey all hospital accommodations. The country was covered by 10 groups of surveyors. I was one of those surveyors, and I dealt with the Sheffield and north Midlands regions in partnership with the pediatrician, Sir Leonard Parsons, and Mr. Clayton Fryers, who is a hospital administrator still living. We visited all the hospitals, discussed the local situation with staffs and management in every one of them, and came up with a report suggesting how they should be reorganized. Every regional team recommended that there should be a regionally-planned service with reorganization of the existing dispersed units into district groups.

During wartime, also, the government commissioned a report on social security arrangements to be introduced postwar for the whole population. The responsible committee, chaired by Lord Beveridge, produced a report written and signed by him which has since been known as the Beveridge Report. The report was written with the assumption that there would be a national health service after the war and it contained another less wise assumption that such a national health service would improve the health of the people to the extent that there would be less ill health to be treated. Today, of course, there is the realization that what it does is prevent people from dying early, possibly preserves their health for a short time, but in the end makes certain that they will need health care over a longer period and perhaps much more of it in their old age.

At the same time, the British Medical Association and other professional groups were also looking at health service. These groups produced their own reports and came out in favor of regionally-planned health services. The BMA, however, believed that only 90 percent of the population should be covered, including cover for the dependents of insured workers, and that the remaining well-to-do or relatively well-to-do 10 percent should pay for their own care—the assumption being that they would pay at a higher rate.

In this wartime period it became necessary to develop some of the specialties, because developments were occurring in radiology and pathology, and in some specialties such as surgery of the central nervous system and the chest, new resources were available for treating patients with ionizing radiation. Substantial improvements were in fact made in those highly specialized services, initially to fill the needs of the military but also in the best interests of the civilian population. Very considerable wartime improvements were made in pathology and radiology services which outside the main centers had not been adequately covered prewar. In 1944 the government published a White Paper which stated the case for a national health service but contained the assumption that new national health service agencies would be bodies which

would finance health care through making arrangements with the existing owners of hospitals—rather like the Australian and Canadian Hospital Commissions were doing up to a few years ago. However the Paper did state that the service was to be comprehensive; all kinds of health services were to be provided for all the people. Negotiations began while World War II was still in progress and a Bill was drafted by the so-called Caretaker Government, mainly Conservative, for about 6 months between the end of the wartime Coalition Government and the election of a Labour Government in the summer of 1945.

In the period 1939-45 there was a generally recognized need for a national health service. We had all kinds of existing services, all probably needing immediate reorganization. There were voluntary hospitals, partial ambulance services, home nursing services, all largely dependent on voluntary funds in peacetime, but most now virtually bankrupt unless financed by government. We had the social security reforms recommended by Lord Beveridge which both government parties were committed to introduce. We had a Labour Goverment with a massive majority and prepared to be radical.

Governments, in my experience, are prepared to be radical only when they have substantial majorities and in the early years of their tenure, because when the next election day begins to loom, thought begins to move forward on lines not entirely in accord with the wishes of those wanting to see radical changes. Nevertheless, in Britain at that time we had a powerful government with one of its strongest members in Minister of Health Mr. Aneurin Bevan. And there were a number of decisions personally attributable to Mr. Bevan or those that were implementations of his party's policies. First, the service must be for everyone and mainly centrally financed, and comprehensive in the sense that there was to be no income limit above which patients were not entitled to free care. This service was to be free at the time of use, though it did allow for payments being made for certain kinds of supplies.

Then came one of the really crucial decisions; one which I think has been largely responsible for such success—and I think it large—as the National Health Service has had. It was decided that hospitals would be transferred to state ownership. Now, it is not claimed that such a transfer could be accomplished in the United States next week, because I know that it could not. But British hospitals were either voluntary—where doctors made no charge for their services and which were nonprofit—or they were local authority hospitals where, again, doctors made no charge for their services and which, again, by law were nonprofit. So we were not faced with the problem of expropriating resources from which people might make a profit. Indeed, profit-making hospitals were excluded, and that meant that a number of small nursing homes where specialists did some of their work were not transferred, but all the hospitals that mattered were transferred to the state.

The next decision was that the management of hospitals was to be local, but that the services to hospitals of the specialists working in them were to be planned and paid for regionally. Further, teaching hospitals which provided teaching resources for medical schools would be administered by separate boards. They were the proudest of all hospitals, of course, and in a way this was a sop to their estimate of their own distinction, but this separate administration had value in that radical changes were being made in medical education at that time and these changes might have been impeded by concentration on service demands. This change meant that new managements

had to be set up, and Bevan's decision was that these managing bodies were to be appointed boards. They would not be the existing elected local government bodies and since they would be new, they could not be expected to administer the whole range of health services, they would be responsible only for the hospitals, which had to be radically reorganized.

Further, it was decided and negotiated with the professions that the hospital staff would be paid by salary but that the general practitioners—who under national health insurance had been paid by capitation and were independent contractors—would continue in that status. Their services, and those of the dentists, and pharmacists who dispensed their prescriptions, would be administered by a body that was the direct heir of the existing body set up ad hoc for running those services for insured workers. This body would consist partly of representatives of the professions and partly of representatives of the public, mainly nominated by the local elected council. However, private practice was not completely excluded. Marginal private practice was conceded, but patients had to be either in or out. If they opted to be private, then they could not have their drugs provided free. Then came a decision crucial to the development of the professions and the hospitals. the general practitioners were to be the channel to other services. This was absolutely vital when the Service was set up, because it prevented everybody from immediately descending upon the hospitals.

The result of all this was a concentration of services under three local agencies. The larger local authorities, 140 of them, retained responsibility for personal preventive services, including immunization, and were given the responsibility for support services like home nursing (which had not previously been their responsibility). They also became responsible for the provision of ambulance services and for the development of things like home help and the after-care of patients. The new regional hospital authorities appointed by the Minister in turn appointed local management committees for running the hospitals. The regional authorities, of which there were 14 in England and Wales for which the Minister was then responsible, were given as their first responsibility the formulation of district plans for the management of hospitals. Later, when the Minister had approved their schemes, they also appointed district management committees.

Conflict about these proposals of the 1946 Act was at that time evident, but the principles were accepted with only minor concessions, and the professions agreed to go into the Service. So far I have been talking about the continuity of progress, and how this progress takes place, step by step, almost unnoticed until someone suddenly realizes that some administrative change is needed and then it comes to public attention. But there could have been different choices at various times. There is a strong tendency in the development of British Government to hang services on existing pegs. For instance, it would have been possible to have created a Health Ministry from the Central Board of Health under the Privy Council in 1872, but it was not done. Health responsibilities were attached to the Poor Law and local government central organization and that probably delayed the development of health services of other kinds. It also meant exclusion of national health insurance from the purview of the same government department when it was set up in 1911.

The separate school health service for the same reason was put under the Ministry of Education and not under the department then responsible for

health. There were other things that happened that might have gone different ways if a health department proper had been created much earlier. For instance, it would have been possible to move faster if the transfer of Poor Law institutions to the health side of local government had been undertaken earlier. But the comprehensiveness of the Service provided in 1946, and the integration of its administration was the real break with the past. It has often been said that this should have been done by stages. But if it had been, I do not believe it would all have been accomplished. If the management of everything had been put under single authorities I believe there would have been absolute chaos. Although, of course, concentration might have been done, perhaps much earlier, if British local government had been principally concerned with health, as local government in Sweden and Denmark was.

Thus far I have not touched upon remuneration or terms and conditions of service of the professions. In this area I merely mention that the question of the level of remuneration of doctors and dentists was considered by two special committees which pondered general practice and the specialties separately. These committees recommended levels of remuneration which to the specialists seemed fairly generous, but to the general practitioners seemed too small. The recommendations, all in 1939 terms, seemed sufficient, but the betterment that was negotiated to bring them up to 1948 levels was quite inadequate for general practitioners. In fact, in the early years of the National Health Service, general practitioners were grossly underpaid. However, this was remedied by a High Court judge, Mr. Justice Dankwerts, whose adjudication was accepted by both the profession and government, and this gave virtually what the profession had originally asked.

That was an early example of government treating the professions unfairly but nonetheless resorting to and freely accepting an outside ruling. I mention also that questions of remuneration continued to bedevil the relationships between government and, particularly, the medical and dental professions, until in 1957 a Royal Commission was set up to resolve the problem.

I mention one other point. All the specialties were to be treated alike in remuneration, but there was a rather clever system under which a professional committee would decide which doctors merited higher awards for the higher quality of service they were believed able to give. A Merit Awards Committee chose one-fifth of the doctors for an additional payment of about 20 percent of their salaries, one-tenth for an additional payment of about three times that, and one-thirtieth to receive roughly double the basic salary. So it will be seen that although all men (and women) were equal, some were more equal than others.

Once the Service was introduced—and it was introduced with remarkably little disturbance—the three local agencies began working independently. Obviously, in such circumstances, there was bound to be some friction or lack of cooperation between them at times. But it was not until some 12 years later, around 1960, that people began to talk seriously about the need to bring the whole Service under one local administration.

The hospitals' new managements were entirely new to the job and a very long shakedown period was therefore necessary. However, the new regional hospital organization at once got down to planning better specialist services, and the principal achievement of the first few years of the Health Service was the universal distribution of trained specialists into areas where they had not

previously been available. They brought really expert specialist care within reach of everyone. The smallness of the country was such that very few people had to go as far as 20 miles to reach the level of specialist care they needed, although the small group of highly specialized services provided on a regional basis meant going farther, but those highly specialized services were made available on reference from the district hospitals.

The capital made available to British hospitals was negligible. There were war damage to repair, especially houses to build, factories to build and a great deal of postponed maintenance of hospital buildings. In the first 10 years of the Health Service there was spent only about £100 million on hospital building in the whole of England and Wales, and nearly all of that was disbursed for maintenance and repairs. Whatever money was available was spent in areas to make existing hospitals more workable—for example, operating theatres, laboratories, X-ray departments, outpatient departments, and so on. The greatest call was to develop services which could be provided within these buildings, and re-staffing largely accomplished this. Actually, we had more money than appeared on the surface, because this was a period when control of communicable disease and of tuberculosis was reducing some of the commitments of the Health Service and the money thus saved was used for improvement of the Service.

During that same period we also began to benefit from the very substantial advance in the practicability of treating the mentally ill, again as a result of the pharmacological revolution; but obviously, with our hospital buildings we were running into more and more difficulty in providing the kind of milieu in which increasingly expert specialist staffs could work. We were faced with rising costs, although the average annual growth rate at fixed prices was only 2.8 percent between 1953 and 1958 and 4.8 percent between 1958 and 1963. It rose a little more after that, but the proportion of the gross national product used in Britain for health care hardly changed through the 1950's, and even through the 1960's into the early 1970's; while the proportion spent on health care in the United States was going up by at least 50 percent, in Britain it went up only about 20 percent.

In the early stages of the Service general practice continued much as it had done. Although it had been hoped to concentrate on health centers and to bring general practitioners into groups, it was only after their remuneration was settled that we really began to get general practitioners to work together—we did not succeed in persuading them to work in Health Service-provided health centers on any scale until nearly 20 years after the Health Service began. Indeed, in the first 15 years of the Health Service only 17 health centers were built in England and Wales. That was mainly because the doctors were fearful of losing their independence. However, we were beginning to get the community nurses, wherever doctors were working in groups, to work in association with them.

There was one very significant event in 1952: founding of the College of General Practitioners. This came about at a time when morale in general practice could hardly have been lower and too many general practitioners were inclined to look upon themselves as the apothecaries who were cast out. The possibility of making general practice in Britain a really worthwhile form of medical activity perhaps was realized only after the College of General Practitioners had begun to show how it might be done.

On the local authority side, this was the decade of immunization. We really got control of diphtheria, toward which we had done far too little until during World War II, of whooping cough, of poliomyelitis, of tetanus and in the next decade measles and rubella. That was one of the larger preventive schemes undertaken by the local authorities, but they also were extending the activities of their reorganized home nursing staff to improve the services available to general practitioners and to patients in their own homes. They gradually were changing their work on well-baby care and antenatal care into a closer partnership with general practice and employing general practitioners for doing this sort of work, as was the case in Denmark for the previous 20 years. Care of the mentally handicapped in the community was being developed at training and occupation centers.

Social work in support of the health services was being improved under the aegis of health authorities, not yet under the separately-organized Social Welfare Service. For example, the organization of a home-help service for patients sick at home was done as part of the Health Service, not as part of the Social Welfare Service, as quite properly is the case today.

What I have described so far is merely the shakedown period of the National Health Service, the first 10 years. At the end of this period it was evident that reorganization of the Service's administration would become necessary and I propose to recount that situation and provide a description of the present status of the National Health Service in subsequent sessions.

DR. MILO D. LEAVITT: How far should we go in affiliating practicing physicians with hospitals, whether they have an open liberal policy or be restricted about it (and clearly there are things to be said one way and the other)? What are your reflections on the choice that was made in Great Britain?

SIR GEORGE GODBER: I will come on to this when I am discussing general practice later on, but briefly I would say that we have come to the conclusion in Britain that general practice is a different kind of specialty which needs support in various ways from the secondary-care facilities in hospital; access, for instance, to laboratory and X-ray and electrocardiographical diagnostic resources. But general practice should be conducted in the community close to the people and should not extend into hospital and take on specialized functions that might better be undertaken by people trained for them.

So long as one recognizes continuity of care as being the responsibility of the general practitioner, and the relationship with the hospital specialist that of working with him during the relatively short period of an episode of illness when specialist care is needed. As long as the two work together I think our system is, for us at least, preferable. I think that in developing postgraduate institutes in all hospital districts we have done one of the more important things to ensure the workability of our system. These institutes are a main meeting ground for the specialists and the generalists from outside. So, I think we will stick to this system as, indeed, Denmark has done. I cannot say the same for Sweden.

DR. JERRY SOLON: Is one of the accompaniments of this a lower hospital inpatient utilization?

SIR GEORGE GODBER. We certainly do have a lower hospital inpatient utilization. We have an annual admission rate of about 110 per thousand for all kinds of hospital accommodation, and the United States has, I believe, between 140 and 150 per thousand. The difference is partly due to your choosing to undertake investigation intensively with a short stay in hospital, because your average stay is shorter than ours. I believe that you make less use of the consultative outpatient resource than we do but I think that the admission rate in Britain will still rise to some extent, though not, I believe, to reach your level. The Russian level is already over 200 per thousand and in Saskatchewan, I believe, it levelled off at 207 per thousand, which is nicely precise, about 20 years ago. If you regard care of the population of a district as always shared between the specialist group in the hospital and the groups of general practitioners in the community, each, of course, with nursing and other professional support, that is a reason why we would expect to have a lower hospital admission rate than you have.

DR. RONALD A. JYDSTRUP: Is that 110 per thousand caused to some degree by a shortage of hospital beds?

SIR GEORGE GODBER: I do not believe it is due to a shortage of hospital beds. In my opinion Britain has too many hospital beds, and my reason for believing this is that too many of them are too bad. Our approach to this is best seen in the new so-called best-buy district general hospitals, one at Bury St. Edmunds, the other at Frimley, already open, where it is endeavored to get a marriage of the community services and the specialized services in the hospital with the shortest possible stay. These hospitals are postulated on a still smaller ratio of hospital beds. We are using about 8.5 per thousand at the present time. These hospitals are planned on the basis of total use (including psychiatry, long-stay care and mental handicap) of some 7 beds per thousand. No, it is not because of numerical shortage of beds so much as of using so many beds in badly-organized old buildings that prevents the maximum rate of turnover.

UNIDENTIFIED SPEAKER: I have a very broad question which you may feel free to limit as you choose. Can you contrast the conditions in Great Britain in 1948 with the conditions we have in our own health system now in the United States, with the ultimate question of addressing which type of model we in the United States should now think of copying?

SIR GEORGE GODBER: Would you think of copying? I doubt whether that is the right answer. I would have thought there is a very marked difference between your position here now and our position in 1945-48, the period when decisions were being made. For one thing, medicine is totally different now. But I would think the great contrast between the two positions is the one that I have just been talking about, the difference between general practice and specialized practice. The two were sharply divided in Britain; they were not overlapping. General practitioners did not fear they would lose patients to

specialists because specialists only took patients referred to them. Internists and pediatricians did not undertake primary care.

Specialists did not fear that general practitioners were going to do specialist work because general practitioners hadn't the hospital facilities for doing it. Admittedly, some general practitioners had been altogether too adventurous in cottage hospitals, but that situation was quite different. I think that you will probably eventually have to reach the same kind of pragmatic conclusion we did—that continuing general practice care is a separate undertaking from that of internal medicine, or pediatrics, or gynecology and obstetrics. Care must be shared, care in any one major episode is not likely to be completely provided by one person. But I believe the most difficult problem is the one we were able to overcome so easily because of the postwar situation in 1946—the separate ownership of health facilities.

I cannot believe that there would be three cheers for any Presidential candidate's proposal to transfer the ownership of all hospitals to state governments, shall we say. So, surely you are going to have to approach this more gradually than we did.

The Swedes and the Danes were lucky. They had it from the middle of the last century and the New Zealanders began that way. We, in Britain, were able to do it because of a particular social and political situation immediately postwar. In the United States it will be necessary to bring this result about by the sort of constraints that the Australian States Hospital Commission or the Canadian Provincial Commissions had exercised in making the development of hospitals conform to a district and a regional plan—if it is decided that America wants it.

It takes a long time to get it going; but once moving I believe you will find that it will run much more quickly than anyone expects. I am here showing the arrogance of believing that the most economical, and in the long run the most efficient, pattern of health care will be that based on a manageable district with a district general hospital at the center, housing an adequate specialist team, with general practitioners providing community care and both, of course, supported by the other professions, especially by nurses, but using a postgraduate institute common to all as the focal point. And in saying that, I have, of course, stuck my neck out.

DR. LOIS K. COHEN: In the historical evolution which you describe you may be dealing with this subject a little later, but I am interested in the kind of impact this had on health professions education. Was it also evolutionary, or abrupt, or what kind of curriculum changes were called for?

SIR GEORGE GODBER: No kind of curriculum change at that point. But medical education had been reviewed by yet another committee during World War II, the Goodenough Committee, which had reported that substantially greater support was needed. Actually, during the war the government announced a large subvention of British medical schools. What happened at the time of the introduction of the Health Service was that all the medical schools not already there were brought effectively within the universities. The support of medical schools was not from the Health Department but through the University Grants Committee funded, at that stage, directly from the Treasury. Today, medical school support comes through the Department of Education and Science. However, it is separate and distinct from the Health Service, so

that the undergraduate education of doctors and dentists is supported through the universities and through different channels from the Treasury. Service interests and perhaps prejudices cannot be made to distort the pattern of medical training. Where the Health Services come in, legitimately, is possibly in graduate education.

Where the British Health Service did come in (and I will be discussing this later) was during the 1960's and up to today by providing the money which substantially supports postgraduate medical education, both graduate training and ongoing education for specialists and general practitioners. That is why there is a postgraduate institute at every district general hospital, largely funded through the Health Service. We go through the exercise of having the filthy lucre washed by being passed through the university, but that is where it comes from.

DR. EUGENE GALLAGHER: Sir George, your emphasis on the importance of the nationalization of the hospital ownership reminded me of something else that I believe occurred in the original formation of the NHS and that is that the practitioners lost their, so to speak, property rights in their practices, that is, the buying and selling of medical practices. I was wondering—and this was a difficult point at the time, I believe—I was wondering why that was incorporated into the legislation and who thought that was important.

SIR GEORGE GODBER: Well, that situation is such a long-dead duck that nobody in the United Kingdom even smells it now.

DR. GALLAGHER: It is a very historical point.

SIR GEORGE GODBER: It is an important historical point, of course. It was incorporated because a national health insurance practice had become a very important saleable item that could go to the highest bidder, not necessarily to the doctor who might best have been established in that particular community. I will have more to say on this when I come to general practice, but doctors are either taken in as partners by existing doctors, with the approval of the executive council, or they are appointed after advertisement by the executive council. A central Medical Practices Committee makes the final choice. Initially, all doctors in practice could have their names admitted to the list in the area in which they practiced. But subsequently they could be admitted only after approval. I can recall one instance prior to the legislation obviating such occurrences, of a former public health doctor who, after treatment for alcoholism, bought the practice of two partners who retired together. Without recent clinical experience, he set himself up in an isolated town with a young doctor hired as an assistant. Now, what kind of service to the public is that? Poor chap, he was dead of his alcoholism within 6 months. That is an extreme case, but it did happen. There were all sorts of backdoor ways, unassociated with merit, of getting into particular practices. If you were a patient your care had been more or less sold to the new doctor. I do not believe this was a tenable situation in a Health Service in which nearly all incomes from practices were from public funds.

DR. CHRISTA ALTENSTETTER: Dr. Godber, you commented on the fact that in England the geographic distance to health care probably does not exceed 10 miles, which suggests that you have solved the problem of maldistribution of physicians. Could you elaborate on the mechanisms and incentives used in order to achieve such a balance of physicians and to encourage them to serve in rural areas and nonmetropolitan areas.

SIR GEORGE GODBER: We haven't solved the problem. We didn't have it, you see, in the same way as in the United States; in North Dakota, for instance, one could go maybe 100 miles for something, we might need to go only five. In Britain the population is so much more compactly placed, and the areas that were shortest of practitioners were, in fact, those most densely populated. The national health insurance had meant that there was an income sufficient to establish a doctor, even in what would pass as a thinly-populated area for us. My wife and I used to live in a village of only 500 people, but there was another village of about 1,000 people only a mile and a half away, and there was a doctor whose practice had been established 120 years earlier by the owner of the big house that lay between the villages, so that he would always have a doctor opposite his gateway. This doctor served several villages. Today, this situation is an anachronism, and eventually he might well join a group of four other doctors already established in a small town, which will still leave everybody within about six miles of the doctor. This illustrates the point that in Britain we did not have a real physician distribution problem, although there were large industrial populations which had, and still have, less than the desirable number.

PRESENT STATUS OF THE NATIONAL HEALTH SERVICE

DR. MILO D. LEAVITT: In Sir George's talk last week, he discussed the evolution of the British National Health Service, including some of the considerations which led to the establishment of that Service in 1948.

Today Dr. Godber's subject is a particularly timely one: The Present Status of the National Health Service. As is health care in the United States, the British Service is facing the problem of increasing costs. Large pay hikes, inflation, and other factors are requiring significant additional government appropriations during a period of competing social priorities. How the Health Service is faring at this time, in Sir George's view, should therefore be of considerable interest to us here in the United States.

SIR GEORGE GODBER: Thank you very much.

I gave you a tremendous dose of history at the first session, I am afraid, but what I was trying to do was show that whatever we do now flows more or less continuously from what we were doing before. New services do not suddenly emerge because Parliament has thought it appropriate to legislate them into being. They always have grown in some way, and in the present situation in the Health Service, one is dealing not with something which has occurred suddenly, but with something having its roots a good way back.

During the last session I endeavored to recount how things had originated in the Health Service and how they had developed in its early stage up to about 1960, about halfway to the present time. I now have to talk on how things have been moving since then, in order to make clear what is happening now, and why.

The new phase in the 1960's began with the adoption of definitive plans for advancing. That means that we took at least a dozen years to settle down to a new method of financing the services that were changed to a different administrative pattern in 1948. The one previous major advance, made during the 1950's, was the development of a specialist service based on hospitals throughout all the country. This development, of course, meant that there had to be considerable improvement in the organization of professional work, mainly based on hospitals, and it also meant that we had to provide for better organization of postgraduate medical education. The development of a greatly enlarged staff of specialists was not something that could happen just because it was wanted. After all, it takes at least 5 years, and preferably of postgraduate training after full registration, to produce the level of expertise necessary for our hospital program.

However, the method of obtaining that education in Britain had largely been one of apprenticeship training, and by 1960 we had not the sort of organized residency programs that were common form in hospitals in North America. So, one of the first things that we had to provide for was a large development in postgraduate medical education. This began with voluntary support by the Nuffield Provincial Hospitals Trust at the end of 1961. Alongside it we started to develop a hospital building program. During the first

dozen years of the Health Service, there had been very little money for capital development, and it had practically all been used for providing additional resources in existing hospitals. But we had reached the point where many of the antique buildings in which we were working had to have their functions removed to something new and planned for modern medical work.

The first thing that Mr. Powell undertook when he became Minister of Health in 1960 was development of a rational hospital building program. Previously, I think we had been afraid to look at the problem. People had said, "It will take £2,000 million," and then recoiled from it. In fact, of course, it will take a good deal more than £2,000 million, and not only because of inflation.

A plan to develop hospital buildings was published in 1962, based upon plans produced by each of the 15 regional hospital boards in England and Wales. It was shown how this planned work would be spread over the next 10 years, how the expenditure on capital work was to develop from something like £15 million a year to more than £50 million a year, and it indicated that the program would be rolled forward year by year, so that in the hospital building program we would always be trying to look 10 years ahead. Of course, partly because of inflation it has cost a great deal more than that, but at least it was an attempt to face up to the needs of the situation.

In that plan, for the first time, the concept of concentrating all hospital work (including psychiatry, geriatrics, and long-stay care) on a single district general hospital for a district with a population of 200,000, give or take 50,000, was promulgated as the doctrine, and this still obtains today as the rational, functional development of hospital services in a country such as Britain.

After the hospital building program had been completed, Mr. Powell simply turned and declared, "Now we have got to do one on the community services." I believed then that he was taking on something much more difficult than the hospital building program but, in fact, in the following year there was published a similar program for the development of services provided for people in the home. Thus, we were there with 10-year plans for both hospital work and for health and welfare services, that is, preventive personal health services and social welfare support, for the whole country, developed region by region and district by district.

Meanwhile, the profession had been vociferous in maintaining that we were trying to run a Service divided into three parts, when we really should be running a single, united Service. Of course, it was united at the center, but at the periphery it was under three different administrations. I believe that this was just as well, because a unified Service could not have been properly managed at the beginning by the new authorities. But a large professional committee was set up by the profession itself, and this produced a report published in 1963 and known as the *Porritt Report on a Health Service for the Nation*, in which was contemplated a single local management for all health services. The report at first received some harsh criticism in government quarters, some of it distinctly unfair, but the report was the stimulus for what government was to attempt 5 years later.

I earlier said that we were concerned about British postgraduate medical education arrangements. A Royal Commission was set up in 1966 to review the provision made for the support of medical education within the Health Service.

The Commission, chaired by Lord Todd, 2 years later produced a report from which developed a great deal of the reorganization of undergraduate and postgraduate medical education.

Also, we were in a very unsatisfactory position in general practice, because the arrangements for payment for general practice had simply been inherited from the previous national health insurance, and these arrangements had the effect, with the changing needs of general practice, of most generously rewarding those providing the least practice facilities for the service of their patients. The disquiet resulting from that situation was at its worst among the best general practitioners. They complained because too large a proportion of the gross income given to them had to be spent on providing resources for practice. This amounted to an unsatisfactory and unfair distribution of general practice money.

A long negotiation with the profession led to a new charter for general practitioners, on which I will dwell at our next seminar. It is mentioned now because it was one of the most important changes occurring in the 1960's.

Later, subsequent to the inquiry into medical postgraduate education, there was issued a report of a special committee which had investigated nursing organization and training (there has since been a further committee). That report recommended the reorganization of nursing services on a district basis instead of on the basis of the individual hospital. The report, of course, supported the district general hospital concept.

Then government—by now it was again a Labour Government—took up the question of reorganization of the Health Service as a whole. A Green Paper, which is a consultative document expressing provisional, but not final, government views, proposed that the administration should be changed very much along the lines that the profession's own committee had recommended. But this particular document proposed that the regional authorities, to which we owed so much of the development in the hospital service, should be abandoned and that, instead, areas of a considerably smaller size should be the basis of future consideration. The Paper was met with considerable hostility, partly from the regions, partly because any change produces hostility in professional groups. It was later substantially modified; the regions were reintroduced and it was proposed that regional health authorities should be responsible for the planning of all health services, and area hospital authorities should be charged with their management. The areas were to be linked with local government areas, but the design of local government was at that time under review. So the actual areas eventually to be chosen could not be determined in advance of the reorganization of our local government areas—and that, too, I will be discussing in some detail, later.

There was then an election, and a Conservative Government was installed. This government did not reintroduce precisely the recommendations of the Green Paper. It issued a consultative document recommending only minor variations, and it accepted the proposals of the Royal Commission on Local Government for a substantial reduction in the number of elected local authorities. The government decided that the areas for health authorities were to become those which were used for other local government purposes, although the agencies would be separate. This subject will be dealt with in greater detail in the fourth session.

An Act was then passed, in 1973, which provided for a change in the administration to take place on April 1, 1974, simultaneous with the reorganization of local government. These two things had to go together, because the social services and education would be reorganized under local government in the new geographical areas, and for liaison purposes the health administration had to fall into the same areas. The social welfare services had already been brought together (including care of the aged and handicapped, and deprived children) from the social welfare aspects of health service, into comprehensive social welfare departments on lines recommended by the *Seebohm Report*. This was a report of a separate inquiry, published in 1972, which also will be discussed later. And so in 1974 we were going to have a change in the anatomy of the administration. But I must point out that this change in anatomy was essentially an adjustment of the structure to the functional changes already occurring in the Health Service.

The change in the hospitals had occurred functionally already. Each district had its own group of hospitals providing comprehensive specialist services, and the building program was designed to concentrate this upon a single district general hospital. Where buildings were multiple, they shared in the service, but services in the individual hospital units were pooled and might be redistributed among them. For instance, in a town such as my own old home town, there were two general hospitals and some specialized annexes. One of them had the obstetrical and gynecological unit, the chest diseases unit and the geriatric unit, the other had the main acute medical, surgical and pediatric beds. These worked together as a single hospital, even though they were 1½ miles apart and separated by a river with bridges that in times of heavy traffic could make traveling difficult. Therefore, they were already working, in essence, as a district general hospital. A new laboratory was provided at one of them to serve them both. The radiological services were provided by a single team; the specialists had been grouped in single teams for the whole district. The postgraduate center, which was built partly with money publicly subscribed, was provided at the hospital where the rest of the development was to take place. The object was to transfer the main work of the hospital group to the one district general hospital, leaving only some outliers for special purposes.

Already, the medical staff had been organized, as mentioned, and under the new nursing staff administration, instead of two matrons or more than one matron for the group, there was a single district chief nursing officer. Following the discussions of a working party of representatives of the department and the profession, there was devised a new system for organizing the work of medical specialists. This was based on divisions: a division of surgery, for instance; a division of medicine, a division of diagnostic services; a mental health division, and so on. This kind of organization, of course, is familiar in the United States, but had not previously been in use in Britain.

This joint working party recommendation had by 1974 been accepted in at least three-fourths of British hospitals. But it was not imposed; it was allowed to develop by agreement.

All district general hospitals, in addition to having medical postgraduate institutes (of which there currently are about 250) provide diagnostic services for general practitioners who can use the radiology or pathology services and, in many cases, electrocardiographic services, as needed.

The number of hospital groups in the whole country had been reduced from about 370 because hospitals for mental illness and mental handicap had been put into the same groups as the hospitals for the physically ill. Hospitals such as sanatoria for tuberculosis, and separate hospitals for infectious disease, had largely become redundant and had been used either for other general medical purposes or had been closed. Within each region, each group of hospitals had the territory for which it was responsible, which today is substantially the district administration, rationalized to fit in with a regional plan for specialist services for the whole.

All regions had developed their own highly specialized services, like neurosurgery, thoracic and cardiac surgery, plastic surgery, radiotherapy and specialized cardiology, and each region had its own regional center for supporting patients with end-stage renal failure. This, of course, is reminiscent of the special developments in the United States. The coordination of specialist services, for instance, such as the linking of facilities for the treatment of head injury between traumatic and orthopedic surgical services and neurosurgery, had been made effective throughout all the regions. The development of specialist services, generally, had been on a coordinated plan for all specialties, and not for individual specialties alone. After all, what you do, for example, for the provision of plastic surgery is linked with what you have already been able to do in surgery for major trauma.

Postgraduate development had included arrangements on a regional basis, guided by a regional committee, for specialized training in each of the fields of medicine, as well as for vocational training for general practice. Screening schemes had been developed, using regional centers for laboratory tests for things like phenylketonuria, or for centralizing the arrangements for examining smears by cytology in screening for carcinoma of the cervix.

The hospital capital program which, in the first 10 years of the Service, amounted to only about £100 million (which did not go very far among the nearly 50 million people in England and Wales) had reached for the one year, 1974, a total of £220 million. It had risen from 3 percent to approximately 12 percent of the total expenditure on hospitals.

In general practice, there were by 1961 about 600 group practices coming together in their own premises, and public health nurses and home nurses were beginning to be linked with group general practice. After the change in remuneration that followed the general practitioners' charter, it became a much more economic arrangement for general practitioners to join in health centers, for which they had to pay rent. They now were reimbursed for the rental of their premises, and the building of health centers for general practitioners rapidly increased to the stage where it is now running at the rate of about 100 a year. The rate of National Health Service investment in health-center development had increased by roughly a hundredfold.

During this period, too, there had been great improvement in the links between hospitals and general practice. They are not nearly close enough yet, but one of the by-products of the development of postgraduate education centers has been greatly improved liaison between special and general practice. And, with the Royal College of General Practitioners' influence mainly responsible, there was a greatly improved morale and sense of purpose in general practice and, especially, serious attention to education for general practice and to the kind of research which is most easily done in general

practice—epidemiology of the common diseases and studies, for instance, on the risk of use of oral contraceptives. That contribution, I think, has been unique, because through no other mechanism could one have gotten the kind of reliable information that we have been able to publish in Britain.

When the new system of remuneration was introduced in the middle 1960's, instead of paying practitioners mainly through standard capitation fees for work in general practice, the capitation fees were weighted for patients' age, and special payments were made for some of the additional services that we particularly wanted to encourage general practitioners to provide. The overall level of practitioners' remuneration was substantially improved, also. We had, in fact, within reach of every hospital doctor and every general practitioner, provision for ongoing education and a good library. I doubt if any doctor in Britian except in a few remote areas now has to go more than 20 miles to reach a library with adequate resources, or to obtain access to the National Lending Library Service, and very few of them have to go more than 10 miles. That, of course, is part of the advantage of being a small country.

On the preventive and support services side, the immunization services had already been largely developed, including rubella and measles; the social support services were greatly expanded under the 1963 plan; the management of the mentally handicapped was transferred to a considerable extent into the community, and there were a large number of places in occupational and training centers for the mentally handicapped. Outpatient care for both mentally ill and mentally handicapped, short-stay treatment for the early case, and day hospital services for many of those who could be managed at home with that sort of support, had also been developed. The emphasis, increasingly, was upon support in the community, where practicable.

In the period 1971-72, the changes in social welfare administration meant that the social support services were transferred to the new Social Work Departments of local authorities. This particularly affected mental health and child care, that is, care of deprived children, and, later, home-help services for sick people.

The work of public health nurses and home nurses had substantially increased, but as the number of babies born at home was decreasing from about 36 percent in the early 1960's to only 6 percent in 1974, the amount of work in the home for midwives was correspondingly reduced, except for the antenatal care that they provided in association with hospitals. General practitioners have been encouraged to take an increasing part in well-baby care.

In the changes in 1974, the one independent preventive personal service—the school health service—was transferred from the education authorities to the health authorities. In the 1974 reforms, the district concept is crucial; the whole of the organization is based on the view that community care is the basis of a national health service, that it requires to lean on a district general hospital for secondary care, that it would be rapidly concentrated on group practices and future health centers, that it will be provided by doctors, nurses, public-health nurses, and midwives working in a functional partnership and linking with the social work services; that the hospital services will all be concentrated eventually on district general hospitals (except for some annexes for long-stay care that may be linked with the district general hospital), and even before the main building has been concentrated in one place, the group of hospitals will work as if it was a district general hospital. The focal point in any

district is the postgraduate institute, and that is now used, as a rule, for postgraduate education for all health professions. I said, "as a rule," and that is premature; it is believed that this will become the general method in the future, and it is already in practice in a considerable number of places.

In each district there is a community physician, who is usually the lineal descendant of the old medical officer of health, but has wider responsibilities. His job is to work with the clinicians and try to provide for them, both in general practice and in hospital practice, information about the health needs of the district and appraisals of the results that they are achieving.

The result of specialization—which has been carried so much further in Britain under the Health Service that the number of consultants is now double what it was in 1948—is, of course, interdependence between family general practice and specialist practice, and not the division that some people have said would be the result. In this, again, the postgraduate institute is the key. It is best exemplified by some of Britain's recent experimental hospital building where what has been called the "best-buy" hospital has been provided on a standard plan to serve a district on the basis that patients are going to be admitted for the shortest time for which they need to be in a hospital. They are going to be discharged home at the earliest opportunity, and that, backed with diagnostic and outpatient services will, we believe, eventually make it possible to meet all hospital commitments on certainly less than eight beds per thousand, and possibly as few as seven. At present we are using about 8.6 beds per thousand population.

Districts do need backup from the regional level. This is not only a matter of providing highly specialized services. There has to be overall planning of specialist services, because, built into that, there must be specialist training and training for general practice. And for that you need the oversight and control of a regional body. You also have to have manpower control in the health professions on a regional basis. Financial control cannot be left with more than 200 separate districts and, because there is a very marked inequality between districts in the amount of money (which has not been leveled up in the last 25 years), a regional pattern of control is necessary to try and secure this equality.

Rudolf Klein, in his book on inflation and priorities, has given some details about the differences in the expenditure in Britain on health service, per head, in different parts of the country. Although, broadly, his thesis is correct, in detail his comparisons are not wholly acceptable because of differences in existing hospital distribution.

The most important influence of the region—based on the university medical school which exists at the center of each of our regions—is the educational program: the graduate program in medicine and ongoing for all in medicine and, dentistry, and some of the higher training arrangements in nursing and the other professions. Support of research needs a regional authority, also. For all these reasons we have, for every region (and there are 14 in England), an appointed authority, designated by the Secretary of State for this purpose. Wales with a population of 2.75 million and Scotland with 5.1 million manage without the region as a level between department and district.

It was earlier mentioned that local government had been reformed on a new area basis. These areas do not always conform to natural hospital districts. The

largest areas (such as Birmingham) have a population of as much as 1.25 million persons, which is far more than could be managed as one health district. And the area for local government is the area on which the administration of health services is based, because there must be contact between the Health Authority and the other services of local government, especially social welfare and education.

Funds from local taxation raised by local government—and that is taxation on property, not an income tax—provide for education, social services, communications, environmental planning and other services and, at the district level, for environmental sanitation. Health Authority staff provide local government with any necessary medical advice at both area and district level

It is essential to have an interface between health and education and the social services. Therefore, the appointed area authorities are not appointed at district level, they are appointed at the area level, and there are 90 areas. Some of the areas have only one district; others have as many as five. The job of the area, in regard to the district, is to produce an overall plan for the area on lines approved by the region, and to appoint a management team to manage the health services in the district. There is no administrative health authority at the district level in a multi-district area.

If it had not been for the design of British local government, the area level in health administration would likely not have existed. But, because of the need to link health with other services, we either had to have a combination of districts—a consortium—for this purpose, or we had to appoint an authority. For various reasons, some of which are political, an area authority was appointed, and it is therefore in some cases slightly remote from the district where the action takes place. The service operational levels are essentially region and district.

At each district level, in order to provide a link with public opinion, there is an appointed community health council, consisting of nominees of the elected local authority for that district, other representatives of consumer interest, and people appointed also by the area health authority. As a further safeguard for the public interest, there is at the center an ombudsman to whom complaint can be made by any person aggrieved at failure of the service to provide adequately for his needs or about anything that may be considered administrative inadequacy.

Well, what has been the outcome? The Service does work, at relatively low cost, but with some needless delays. But each patient does have a general practitioner to whom he looks first to get him any form of health care that he needs. Everyone does know, and broadly trusts, his own general practitioner for that purpose. Specialist services have been leveled up over the whole country, though they are still short of the level, either in numbers or in some respects in quality, that we would desire.

The supportive and preventive services have been improved, and are much more uniform than they used to be. But they depend on the efficiency of the local authority, and there are, for example, considerable differences in the proportions of children immunized against infections. Many authorities have more than 90 percent of the children in their district immunized fully, but there are some with proportions below 70 percent. There are complaints, usually about failures of communication or about delay. However, they are not

more than might be expected in a Service which probably has a million patient contacts a day.

Long-term care, which before 1948 was simply abysmal in most areas—and probably the same is true of most countries—is now good in some areas, moderate in many areas, and in some areas still frankly bad. There are considerable difficulties in building up real quality geriatric facilities and some long-stay psychiatric facilities. Even after a lapse of more than 20 years (because it is only about 20 years ago that we in Britain really began to appreciate the needs and possibilities for improving long-term care) the efficiency could still be substantially improved.

The cost is rather less than one-third of the expenditure on health services in the United States, according to Maxwell's book. It is currently about 5.4 percent of the gross national product, compared with at least 7.6 percent of a much larger gross national product in the United States. There was a large increase in that British proportion last year—it had been about 5.0 percent—but that was simply because one of the features in the Health Service had been underpayment of many lower-paid staff members and because the GNP fell. A 9 percent increase in Health Service costs in 1974 was attributed to increases in salaries and wages, 8 percent, and increased other costs, only 1 percent.

In capital investment there has been substantial delay and lack of totality. In the 1950's we missed out, and capital investment in the present financial circumstances necessarily is having to be checked. Further, it was not going, even before this, at the rate the Service clearly needed to catch the back-log.

Regarding the output of the Service: In 1949, 2.9 million inpatients were treated; that is, 2.9 million discharges from hospitals took place. By 1974, the number of discharges in England and Wales had risen to about 5.4 million. Thus it will be seen that there has been a very substantial increase in inpatient work, although there has been a decrease in the number of hospital beds in use. Also, there are far more old and handicapped people being sustained under home care than ever before, and that is by choice. The number of psychiatric beds in use has, over the past 20 years, been reduced by something like 30 percent.

The average length of stay in geriatric beds fell 20 percent in the past 10 years. The turnover in the same number of beds increased 25 percent in that period. This is a great increase in inpatient turnover, for we have fewer beds and shortened stay. The turnover increase has been most noticeable in mental illness, where there are now 20 percent fewer beds provided and 25 percent fewer occupied, with the turnover in the last 10 years going up from 1.1 to 1.6 per psychiatric bed per year. Most of these beds, of course, are long-stay, but most patients are now staying for much shorter times.

The waiting list for admission to all hospital beds has remained much the same throughout. Because of the turnover, the waiting time is less. However, if there is still a waiting list approaching half a million—even if perhaps 25 percent of the list consists of patients waiting for tonsillectomy—it is far too long. Old patients wait too long for operations for cataract; middle-aged women wait too long for gynecological repair operations; patients with herniae, especially older patients, wait for months while they should be kept waiting only for days or weeks.

The worst feature in the Health Service at the present time is the morale of those working in it. This morale problem arises largely from the disputes over

remuneration that led to strikes among some of the lower-paid workers in 1973, among other such workers and nurses in 1974, and to slow working by even some of the doctors earlier in 1975. This situation is partly due to the fact that the amount of national resources made available for health has been less than those people know has been made available in other countries. Even within Britain, the advantage given to Scotland in money per head for the NHS is in excess of 20 percent, and the staffing in Scotland is much higher than in England. The level of discontent in Scotland is correspondingly lower. Should an outside comment on this be desirable, rather than my own, since I am committed to the National Health Service as an institution, I cite an interview with Robert Maxwell published in the *British Medical Journal*, August 15, 1975. This amounts to an unprejudiced authority recorded in a sometimes prejudiced journal. The interview was not absurdly optimistic. He did say that confidence and belief have been undermined and urgently need to be restored. He also said that of the organized services of the West, the British Health Service is the most economic known to him. Comparison with the USSR is, of course, far too difficult because one does not know what values are there at all, but Mr. Maxwell declared that any alternative would be less complete, less humane, less efficient and more costly and, I would add to that, would almost certainly be economically worse for the doctors as a whole.

In dollar figures, the total Health Service cost in the last financial year was $7.25 billion for England alone, the percentage of the gross national product was 5.4; the cost per head was roughly $155 and that is, I believe, about one-third of the comparable figure that would have applied to the United States for the same year. I already mentioned the increase over the previous year.

To give some idea of what was happening in the 20-year period 1953 to 1973, it is mentioned that total public expenditure in that period increased by 99 percent. Personal social services expenditure increased by 506 percent, and education by 274 percent. Employment services increased in cost by 253 percent, while social security benefits increased in cost by 159 percent, and the National Health Service by 141 percent. Thus it will be seen to be not entirely an unfair statement that the National Health Service has not received treatment comparable with some other services. But the problem at present is not to get from government the additional £600 or £700 million at least needed for development, but to discover how to do better with what is available, because in the kind of financial situation obtaining in Britain at present, the only way one could get that £600 or £700 million would be by raiding other services, and no service would or should willingly surrender sums of that order.

Once again, I have gone on for far too long and, perhaps, been too discursive, nonetheless there is a little time should anyone require elaboration of any detail.

DR. DONALD R. KORST: You mentioned, Sir George, that an optimum figure for population served by a hospital was 110,000 to 200,000. What have you found to be an optimum size for a district?

SIR GEORGE GODBER: We would use the same. When I said that, I meant that a district of that order of population needs a district general hospital. I think it very important to correct the idea of some hospital-bound specialists

that a hospital needs about 200,000 people to provide it with pabulum. However, one must look at this in terms of district needs. What a district needs is not just a district general hospital. In our idiom it needs a district general hospital at the center of a complex which includes health centers where community services are based, and has as its focal point a postgraduate institute. So, when I talk about districts, I talk in terms of both hospitals and community services.

DR. KORST: How is that arranged in the more rural situations, where this involves a fairly wide area?

SIR GEORGE GODBER: Well, again, it is not arranged. You need what you need. If one lives in an area, as I used to, of 170,000 people with a county town of about 80,000 population as its center point, with the rest distributed among small towns and villages within a radius of perhaps 15 miles, then what is needed at the center is what is needed by 170,000 people. One would not think in terms of an ideal 200,000-serving hospital of so many beds put down there, and then draw a line on the map to include 200,000 population. In some ways, that is what is seen in a Russian rayon, where the decision may be a standard hospital followed by allocation to it of the population within so many blocks.

In Britain, we would look at it quite the other way. Even in the large cities, one will find them sectorized because traffic in them is radial and people using public transport come along certain routes, and the hospital ought to be located at the nidus.

DR. LOIS K. COHEN: You mentioned the cost of the service towards the end, and I was wondering whether you might say a few words about the fact that the National Health Service has begun to charge for dental services, in particular up to 59 percent of the cost of certain services, and what kind of impact this has had on utilization?

SIR GEORGE GODBER: The Health Service has been charging for dentures and certain kinds of dental service for more than 20 years. Thus it cannot be said that this had a specific impact, except in certain directions. The charges tended to be proportionately higher for the provision of dentures, for instance, than for conservative treatment. The charges were waived for people under age 21, for pregnant women, and they could be paid in other ways for old people. They were deliberately [illegible] to encourage conservative dentistry, and they have certainly had that effect.

The provision of a general dental service has had very notable effects on the frequency of emergency dental care. The number of occasions when someone goes to a dentist for emergency treatment has gone steadily down throughout the Service. I would have to do a little research in order to provide the actual figures. The cost of dental treatment has not been an obstacle to obtaining it. The British are notoriously careless about their teeth, and the dental services that were available before 1948 were not adequate. If everybody had come along asking for dental treatment in 1948, the services would have been unable to cope. But, because of carelessness in the population as a whole, we got by. I

am not speaking in favor of charges, but I believe the use of charges to channel treatment in the most desirable directions has, in fact, been effective.

DR. EUGENE GALLAGHER: This is in the light of Dr. Cohen's question. I believe there has for a number of years been a proposal that hospitalized patients in the Health Service should pay for the cost of their board, or something like that. Do you think this will ever be enacted, and what is your reaction to the proposal?

SIR GEORGE GODBER: I am quite certain that it would not be enacted by the present government, unless they were in a situation even worse than they conceive it to be now. Nevertheless, I can tell you that every government, of whatever color, has looked at the effect of doing this. I do not mean that any Labour Government thought they would do it, but that every government has had before it information of the effect of doing this, and has decided against it. I have some figures here. In order to raise £50 million for the Health Service, a charge for what you might call the "hotel costs" of hospital, of £6 per week, would have to be made, on the assumption that 50 percent of all patients would be exempt (because it would be of no use to levy charges on many of the elderly or the mentally ill) and it would not normally be thought right to levy them upon children. And there would not be a large contribution unless a very substantial charge was made. I was talking about £600 or £700 million more being needed. It can be seen that in order to get £500 million, one would have to levy a charge of £60 a week, and that would still be a great deal less than the actual cost of maintaining a bed. Of course, not all the costs of the Health Service are in the hospitals; but £60 a bed would provide the £500 million. If one looked for only one-half the £500 million from hospital service, which is about a fair division, I suppose, that would still mean £30 a bed. I do not believe any government would face a charge of that order; they would look for other ways.

DR. STUART SCHWEITZER: Do you believe that charges would have value—not as a source of revenue, perhaps—but as a mechanism for redirecting utilization? Would these have a beneficial impact on either length of stay or choice of ambulatory versus inpatient services? Would this situation be desirable, at least to some extent, in Britain?

SIR GEORGE GODBER: I may be giving you a purely personal opinion, but I think its effect would be heaviest on those to whom it was most unfair. After all, the average stay in Britain is not as short as in this country, it is true. But a good many admissions that take place in this country would not take place at all in Britain. For instance, in the United States, about 250 percent as many cholecystectomies are done as in Britain. Well, I do not wish to do anything that would make it possible for us to multiply the number of cholecystectomies by two and a half. I would not want to see the woman who now stays 6 days after delivery being urged by her hard-up husband to come home after 3 days; I do not think it would help. The British admission rate is very much less than in the United States or Denmark or Sweden, and not much more than one-half that in Saskatchewan, so I do not think that it would have a desirable effect at all. It would be simply a revenue-raising device.

DR. LEIF HAANES OLSEN. You mentioned local property taxes being used for financing some of the services. Did I understand correctly—possibly I am jumping to conclusions—that there might not be substantial separate subsidies from the national government to finance health-care delivery? Or how is it organized and how is it arranged, the whole financing of the total package of health services as they are available on a regional basis?

SIR GEORGE GODBER: The area health authorities and regional health authorities are appointed authorities. All their funds come from central government. The personal social services are run from local rates—these are property taxes—by local government, not by the area health authorities. Government does make a grant to local authorities for all their services at a rate which is of the order of one-half. It is varied so that the poorer authorities, with the smaller resources for the population they have to serve, get a higher percentage grant than the relatively well-to-do authorities. But the Health Service proper is financed from central funds, including an insurance contribution by employed workers. The insurance contribution is quite a small part of the whole that the Health Service costs. The contribution is paid only by those who are at work, and the payment of that contribution is not a condition of access to the Health Service. Entitlement does not depend on that; entitlement depends on your need of the service, not on past contributions, so that one would get care even if a visitor to the country. It would not be refused if it was care that was needed, even if only on an overnight stop at Heathrow Airport.

DR. SCHWEITZER: Can you comment on the role of the private sector in Britain and, especially, the new regulations concerning the use of private beds within Health Service hospitals?

SIR GEORGE GODBER: I will be discussing that in one of the later talks. Broadly, the private sector in the hospitals has been only about 2 percent of all admissions. The voluntary insurance systems which support private patients had only about £36 million a year premium income, whereas the Health Service as a whole then cost more than £3,400 million. Thus it will be seen that in Britain the private sector is but a tiny factor. I know it has been announced that Britain's present government is going to phase-out pay beds in hospitals. But that has not yet been done; there are still about 4,000 of them and there are still some 120,000 patients being admitted to them annually. But the comparison is 120,000 against approaching 5.5 million patients.

DR. COHEN: You commented earlier about group practice, that in 1961 there were already about 600 general group practices. I wonder whether you can elaborate on the forms of group practice and their services?

SIR GEORGE GODBER: I should have said that the group practice—and I will deal with this in detail when I am discussing the details of general practice later on—means only groups of general practitioners with the nurses, midwives, and public health nurses who work with them. The nurses are paid by the health authority; they are not the doctors' staff in the sense that these employ them.

THE DEPARTMENT OF HEALTH AND SOCIAL SECURITY AND THE LOCAL AGENCIES

DR. MILO D. LEAVITT: Sir George Godber, Scholar-in-Residence, will today discuss the third topic in his lecture series on the British National Health Service, entitled The Department of Health and Social Security and the Local Agencies.

In the first presentation we covered the evolution of the service, including the considerations which led to its establishment. Last week Dr. Godber discussed the present status of the National Health Service, including some of the problems facing the system today. Today he will cover the manner in which the system is structured, namely through the Department of Health and Social Security and local agencies. As many of us here are employed through the U.S. Public Health Service, responsible not only for advancing medical knowledge, but also for improving the health of the American people, today's topic should be particularly relevant to our interests.

Once again, Dr. Godber will allow time for questions at the end of his presentation.

SIR GEORGE GODBER: Now, you may think that the first two talks were excessively historical, but in fact I don't think it makes much sense simply to take a photograph of what we have, the situation of today. I believe one has to look at how the institutions evolved and how practice evolved, because otherwise mistakes are certainly going to be made by the reformer who comes along and looks in strict logic at a pattern which may not now be very logical, and tries to take short cuts. I am sure that the United States cannot do this sort of thing in developing health services or social services, and this thought lies behind an answer I gave at the end of our first discussion when I was asked which pattern did I think the United States might copy.

I don't think there will be copying of any pattern. Methods that have been used elsewhere may be adapted to the American picture, but I do not believe that the British National Health Service is an exportable asset (and I do believe it *is* an asset).

In the first two talks (and I shall do the same in this one) I was trying to present to you the pattern of evolution and the structure rather than great detail about particular aspects of the Health Service, which I hope to cover in subsequent discussions.

The Department of Health and Social Security is the lineal descendant of the General Board of Health, which was set up under the Privy Council in 1848. There was no central government agency responsible for health before that, although there had been a short-lived board set up in the 1830's, when cholera was thought to be coming to Britain in one of the earliest pandemics of which we have record. There had been a Poor Law commission operation from the middle 1830's, and the local Poor Law authorities had marginal health interests, because it was their job to look after the indigent and among the indigent there would always be some who were sick. Admittedly, people

tended not to last long in those days, but still there would be some sick persons.

Poor Law institutions for the care of the destitute commonly included infirmary blocks, which were a kind of primitive hospital. The Poor Law commission was set up to provide central guidance for the Boards of Guardians, which were the locally elected Poor Law authorities.

The first really serious attempt to introduce local health control through sanitary services was as a result of an Act of 1848, and the first local health officers were appointed then, in Liverpool and London, and the Board of Health was appointed in London. The Board of Health was simply an advisory body answering to the Privy Council, and it appointed as its first medical officer, in 1856, Dr. John Simon, who since 1848 had been medical officer to the City of London. He moved to the central authority, and he is one of the great figures in the history of public health in Britain. In 1856 he wrote the first of the annual reports on the state of the public health covering that year, and he was responsible to the Privy Council which in turn was responsible for government under the Crown, in detail, only in those areas where there were not established departments of government such as the Home Office, the Foreign Office and the Treasury.

In 1871 the first independent department of government dealing with health was established as the Local Government Board. It had a President who was a minister in the government and a Member of Parliament, but no other members. This minister and his department had central responsibility for guiding the local bodies administering the Poor Law, and the elected county, borough and district councils later established to carry responsibilities previously undertaken, if at all, only by parishes. The department was strongly biased toward Poor Law administration because that was the first area in which there had been substantial reform beginning in the 1830's. The Board started a vigorous effort to improve general sanitation through the local councils, which soon were required by law to appoint their own health officers, whose security of tenure and therefore, to some extent, independence of judgment was guaranteed. A local authority could not dismiss its Medical Officer of Health without consent of the President of the Local Government Board. That was a very necessary protection when, among the people elected to the local council, there would almost certainly be some of the people owning slum property which the Medical Officer of Health might want to condemn.

That was the main drive of central and local government in the second half of the nineteenth century, and it was reinforced in the control of communicable disease by laws which required notification of specified diseases and the provision of isolation hospitals. Separate laws also required provision, by the counties and cities, of hospitals for the mentally ill, and an autonomous Board of Control, not under the authority of the President of the Local Government Board, was established to supervise mental hospitals.

The larger local councils were given increasing responsibility in health and other fields, including public safety, education, provision of roads, water supplies, sewage disposal and, later, housing. Although health responsibilities increased after 1900 to include obligatory personal health activities for schoolchildren in 1907, and optional services for the care of preschool children and expectant and nursing mothers, they were never more than one duty among many, and that is the contrast between the association of local

government with health services in, say, Sweden or Denmark, or New Zealand, and Britain. The principal responsibility of a local authority, a county council in Sweden, is health. Eighty-five percent of their budget goes on health, and therefore the locally-elected council takes an intense interest in its health services and a great pride in its hospital services; whereas in Britain, with many other functions depending on the elected council, health was likely to be a less prominent activity.

The Local Government Board had central responsibility for the environment, for housing, and these health activities, but in them the Poor Law was still a dominating influence. It was perhaps for that reason that when national health insurance, to provide primary care for insured workers, was introduced in 1911, it was given to an autonomous commission, as mental health had been, not to the Local Government Board which had the other health responsibilities. School health had already been assigned to the Department of Education, which was another board having a chairman and no members.

Later, during or just before World War I, when tuberculosis and venereal disease services were thrust upon local authorities, they also were the responsibility of the Local Government Board. Subsequently, in 1919, a Ministry of Health Act was passed to concentrate the health concerns of the government under one department, responsible to a Minister of Health. The new ministry still had responsibility for environmental hygiene, including water supply, sewage disposal, refuse collection, and that sort of thing. That kind of activity had been most important in improving the standard of health in the second half of the previous century and, for that matter, in the first 20 years or so of this. The ministry was still responsible for food safety, housing, for the central administration of the Poor Law and environmental hygiene, but it was also given a new range of responsibilities for maternal and child welfare, for tuberculosis, for venereal disease, for controlling communicable disease, and for the growing health needs of Poor Law institutions. The latter mostly now had large infirmary blocks, because from 1900 onward, the life expectancy in Britain was rapidly increasing. The number of people reaching later ages, and therefore likely to be grouped among the chronic sick, as in the United States, was steadily growing. As a result, local authorities were beginning to develop their own general hospitals under the Poor Law system. There are in Britain some hospitals built since 1900 simply as a Poor Law, and not primarily a health, exercise. From 1920 to 1939 the health ministry recruited staff to conduct surveys of the health activities of local authorities, and to give them detailed advice. The years between the World Wars were years of rapid expansion of personal health-care services provided by local authorities, though not general practice or primary care, except as part of relief for the indigent.

The National Health Insurance Commission was brought over to the new Ministry of Health in 1920; the commission itself was dissolved, and its staff simply attached as one of the ministry departments. I joined the Ministry of Health staff in 1939, and it certainly would not be true to say that between 1920 and 1939 that particular branch of Ministry of Health activities had really been absorbed into the mainstream. It still tended to operate very much as if it remained a separate department. The Board of Control, which was responsible for the central supervision of mental hospitals, was under the authority of the Minister of Health, but it was not a part of the Ministry.

The non-hospital personal health-care services that were being provided by local authorities were essentially complementary to the main area of personal health care, which was obtained either through national health insurance or privately.

The Public Health Law was consolidated in 1936, and the Local Government Law was consolidated in 1929 and 1933. Consolidation gave no control over voluntary hospitals but they were brought into civil defense preparations which were made in 1938 and 1939. There was increasing concern for health and personal health care, shown by the large between-wars development of maternity services, following agitation about the maternal death rate which at one stage had reached 4 per 1,000 births, and pressure for the provision of some special services like treatment for cancer. These led to the introduction of a special Act in 1939 permitting expensive services such as the use of ionizing radiations, mainly from radium, to be provided by public funds.

During the period 1939 to 1945, the Ministry of Health was responsible for the medical side of civil defense, and for much of the treatment in the United Kingdom of service casualties—not all of which went to Army, Navy or Royal Air Force hospitals, although such existed. A large proportion of casualties brought back to Britain after the invasion of Europe were treated in civilian hospitals, which had been specially staffed, and in some cases extended for that purpose. This meant that, in the Ministry, health was beginning to preponderate over environmental and Poor Law concerns which had dominated it in the earlier years. A team of administrators and doctors from this group, a small team, was built up in the early 1940's to plan the National Health Service, and that team continued with additions to guide the introduction of the Service up to the 1946 Act.

The Ministry of Health's responsibilities had become two wings: the old local government wing, which was concerned with housing, water supplies, sewage disposal and that sort of thing, and the new health wing, concerned with medical care and prevention and with some of the supporting social services. The National Health Service legislation, which was part of a program that had three elements—health, assistance against destitution, and social insurance—therefore was introduced as part of a complete reorganization under government of social security services of all kinds.

The idea was to bring together personal and preventive health as one group, assistance to the indigent as a separate social security group, and insurance systems covering cash benefits in periods of ill health, retirement pensions and unemployment benefits. Personal and preventive health and assistance to the indigent stayed with the Ministry of Health—that is, direct, not cash, assistance—and insurance systems and cash assistance to the indigent went to the new Ministry of National Insurance, which was set up and took on these new responsibilities on the same date as the introduction of the National Health Service.

The one component left out of the Ministry of Health services at that time was town planning, which was a new development in Britain. This had gone to a new department, and that became significant later on. At the time of the introduction of the National Health Service, in 1948, the Ministry of Health still had large housing and local government responsibilities.

Special hospitals for mentally-disturbed persons before the courts were in fact the only directly-managed clinical services provided by the health department. The welfare of deprived children, which had been with the health department, was transferred under a Children's Act to the Home Office. The Ministry of National Insurance, which had taken on the insurance responsibility, did not have responsibility for war pensions at that time. This remained with a separate Ministry of Pensions, which also provided hospitals for pensioners as does the Veterans' Administration here.

It was clear that there had to be further reshuffling to provide a logical distribution of central government responsibility, and in 1951, that took place. The separate Ministry of Town Planning took over the responsibility for housing, water, sewage and the rest as a Ministry of Housing and Local Government and, for the first time, the department centrally responsible for health was dissociated from the other responsibility of central guidance for local government. This left the Ministry of Health a much smaller department, the only disadvantage of which was that it became less important in the hierarchy of government departments. The minister ceased to be automatically a member of the cabinet, and to that extent might have less influence in the councils of central government, and also less strength when it came to seeking additional funds for the health services.

Scotland was separate and had a separate Secretary of State for Scotland, who was always a member of the cabinet, and this may have been a significant factor in the larger and progressively increasing amounts of money in proportion to population made available for the Health Service in Scotland. That still left Britain with a separate Ministry of Pensions, which was dissolved in 1953, with the clinical services being transferred to the Health Department. These were a number of hospitals for pensioners, and the limb-fitting service, which had been used for amputees, whether service or civilian. The change left the pensions responsibility to the Ministry of National Insurance, now called the Ministry of Pensions and National Insurance, to complete the responsibility of that department for cash assistance in all forms.

So the Ministry of Health now had all personal care and preventive health services—except those for the medical services of the Armed Forces, the medical services for deprived children, the school health service, the prison medical service, and occupational health. Although quite a long list, it left the bulk of health responsibility with the then Minister of Health, and in order to provide coordination with some of the other services, the Chief Medical Officer to the department was also Chief Medical Officer to the Department of Education, and to the Home Office. He was also responsible for securing medical advice for the Department of Housing and Local Government, and to the Ministry of Agriculture and Food. There was thus a very large measure of coordination on the professional and technical sides. The Chief Medical Officer was also an assessor at the Medical Research Council, and entitled to attend all its meetings. Therefore, at that time, only military and occupational health were completely detached from the main health department.

There was still a Board of Control for the mentally ill and handicapped, but it was operating as a psychiatric department of the Ministry of Health, and the hospitals were all part of the National Health Service. It existed only because it was felt necessary to preserve an independent entity dealing with some questions of freedom of the subject, as until the Mental Health Act of 1959,

the majority of admissions to mental hospitals in Britain were under compulsory certification. Now, only a very small proportion of patients admitted to mental hospitals are certified and can be detained; the great majority are voluntary patients.

The final major reshuffle came in 1968, although there were some elements to come in afterwards. The Ministry of Health, responsible for health care and related social services, and the Ministry of Pensions and National Insurance, (today called the Ministry of Social Security) responsible for the whole of the pension system and cash support to the destitute—these were to be brought together into a single Department of Health and Social Security, under one Minister. The Secretary of State became responsible for one of the largest departments of government, and therefore a more powerful voice in the cabinet—though, as I shall show you in a moment, not necessarily a voice only concerned with health when there were arguments about money.

Broadly, the foregoing covers all personal health care and prevention, including since 1974 the School Health Service, the personal social services provided by local authorities including care of the aged, the handicapped and, since 1971, deprived children, when that group was brought back from the Home Office, in one block. The social security services covered all kinds of insurance payments and supplementary grants including special grants provided to secure attendance upon people who were housebound. It still left the department's Chief Medical Officer responsible for advice to outside departments, particularly the Ministry of Agriculture, Fisheries and Food, and the Department of Education and Science (on problems of education, for instance, including medical education) to the Home Office on the Prison Medical Service, and even a little group concerned with the overseeing of the prevention of cruelty to animals in laboratories, and to the Department of the Environment on chemical and other hazards in the environment. And today this officer is now a member, not merely an assessor, of the Medical Research Council.

Therefore, occupational health is the only anomalous group left, but this is now under a detached authority, not directly under a ministry. There is close personal liaison across the whole of the medical and related fields.

The arrangement is logical, but it has one potential major weakness in that that one minister fights for funds for both cash and care. Perhaps it is not fair to say it *is* a major weakness, but it could be a major weakness. Out of a limited social budget he, the minister, may be unable to do justice to both, and he might lean to one or the other side for reasons of personal inclination or, conceivably, electoral attraction. At a time of retrenchment it might seem easier politically to cut services than cash allowances. The solution to this is probably precaution rather than change.

That has been the pattern of the evolution of the central department during the life of the National Health Service, and the pattern of local agencies reflects the central developments. Elected local government began with Boards of Guardians in 1834, controlling areas which were simply combinations of parishes which had previously carried the Poor Law responsibility from Elizabethan times after the dissolution of the monasteries. City councils also existed, and counties had historical boundaries going back even further, sometimes to areas that in Saxon times were suitable to recruitment of the militia, and not necessarily very suitable boundaries for organizing today's

health care. Counties were later divided into urban and rural districts, whose councils' main functions were basic environmental control, and the control of communicable disease. Personal preventive health services were simply given to the larger authorities as they came along. Treatment services were added to the larger authorities when the Poor Law was broken up, finally, and the function and institutions went to counties and to larger towns which had county status--about 140 authorities in England and Wales, with a population then of less than 40 million.

The size of those authorities varied from fewer than 20,000 in the tiny County of Rutland to 4 million at one stage, in the County of London. The boundaries were quite irrational, but political resistance to changing them was always extremely strong, until finally in the 1960's a commission recommended a reorganization which was put into effect at the time of the change in health service administration in 1974.

The definition of units naturally had functions other than health in mind even then, and the boundaries then were not designed primarily to fit health needs. For that reason, and because there was no regional unit, and the professions were strongly antagonistic to control by elected local government, a separate administration (though using similar areas) was chosen for the National Health Service. Local government finally lost the management of any health services except for environmental control.

The final break came with 1974's changes, but part of the change had occurred at two earlier stages. In 1911 when national health insurance was introduced, it assumed in general responsibility for contractual arrangements with general medical and dental practitioners and pharmacists and the sight-testers for those services. The local committees were roughly of equal numbers from societies and the professions for each county or city. In 1948 when participation by the Friendly Societies and independent insurance ceased, similarly constituted bodies, called Executive Councils, were composed of professionals, nominees of the elected local authorities, and a few others. So for the first time local government was indirectly getting a foothold in the management of primary health care.

In 1974 all these were transferred to management by the unified health authorities, and special committees (the Family Practitioner Committees) had to be set up by each health authority with a specified constitution of the same kind.

In 1948, when all hospitals were transferred to the Ministry, 14 English regions and Wales, plus five regions in Scotland, were defined for the administration of hospital services. Each had an appointed board to plan specialists' services, employ all the senior medical and dental staff and undertake necessary capital building work. Each regional board defined hospital groups, not geographical districts, and appointed management committees for them. Local authority members were chosen, not as delegates of their authority, but as persons for membership of both the boards and the committees. Hospitals that were associated with medical schools were separately designated and given boards of governors consisting of one-fifth representatives of regional boards, one-fifth from the university, and one-fifth from the senior medical and dental staff. They were answerable directly to the Minister and not to the regional boards.

All the money for hospitals and for the family practitioner services came from central taxation, plus a central contribution from insurance funds. The county and city councils that ran the personal, preventive and support services had approximately a 50 percent subsidy from central taxation for their services. They ran the preventive and support services of home nursing, home midwifery, public health nursing, home help in time of sickness, immunization, provision of health centers, ambulances, after-care services, mental health support, and well-baby clinics. Separately, they were also responsible as education authorities for the School Health Service under the Department of Education. This meant a very strong department influence on hospitals. the running cost of which was about one-half the total health funds for health and personal social services, and the capital development about 7 percent. So the cost of hospitals is the largest component in the expenditure of the health side of the department.

The family practitioner services—primary medical care, dental care, and pharmaceutical services and services for providing spectacles—add up to only 18 percent of the total expenditure, and the expenditure on local authority health services only 6 percent. Sixteen percent of the present Health and Social Services budget is for the personal social services which are often in support of the health services.

Since 1974 in England all finance for health services has come from central taxation and small contributions from insurance and payments by patients; it is all distributed through regional health authorities to area health authorities. In 1974 all services were brought together in England under the regional tier. The Secretary of State appointed regional health authorities for 14 regions in England and chairmen of area health authorities; the regional health authorities appointed the members of area health authorities, including some nominees of the local authorities and the professions. Thus the funds coming from central sources were all administered by appointed authorities.

The 14 regions are health regions approximating those of the old regional hospital authorities. In all cases they now follow local authority boundaries, because of the need to avoid confusion between health and local authority. The area health authorities each administer the services within the area of a local authority, but their membership is appointed by the regional health authority and they use the same areas only in order to secure closer cooperation with the personal social services, education, and the other services provided by the elected authorities; there are 90 of them.

The first task of the area health authorities was to decide whether the health services in their areas had to be administered by one or more districts; today, most of the authorities include more than one district. They appoint, for each district, a district management team, which is a multi-disciplinary group including an officer responsible for finance, a senior administrator, a representative doctor from general practice and another from the hospital staffs, and the community physician (whom we will discuss in one of the later sessions) and a district nursing officer. The district management team is the key to the management of the Health Service, because it is at the district level that services are effectively coordinated. There is no administrative council or committee at that level; the district management team is answerable directly to the area authority.

The area authority is necessary because the elected councils of the counties have the responsibility for personal social services; and there has to be close communication between health and social welfare and because the health authority is responsible for the School Health Service, also education.

This is the really difficult part of the present organization. It would not have been possible to have had a purely health-planned administration, an appointed authority for each district for all the health services, and an appointed regional authority for each region for all the health services. In those circumstances it would then have been necessary to arrange that the district authorities combined in order to secure close coordination with social welfare and with education and housing and other relevant services which were the responsibility of the elected authorities. For strong political reasons the authority was set up at the area and not the district level. That means that there are 90 of them, and the system is not broken down between something like 200 district authorities. It would have been possible to dispense with the regional authority, giving all the power to the area and allowing for regional functions through a combination such as exists in Sweden, where counties combine to provide some of the services. Had that been done in Britain, the link with universities would have been lost, and there would not have been a broad enough basis for planning some of the specialist services—or for taking on education, particularly postgraduate education. However, the end stage in organization has not yet been reached, I am sure. It is not thought that the system can be interfered with again within the next few years, although it is obvious, from some of the views expressed on behalf of the present govemment, that they do not entirely like the system taken over from their predecessors. Metamorphoses of this kind can be undertaken only every so many years, and I believe that the present system is almost certain to run for at least 10 years—that is till the late 1990's at least.

To return to the subject of the Department of Health and Social Security, I said that the Chief Medical Officer in the department had slightly wider functions and goes outside the department in some of his responsibilities. Within the department, there is something which in the United States possibly would appear very strong. There are parallel hierarchies, administrative and medical, and there are chief officers in other professions: dental, nursing, architectural, engineering and pharmaceutical. The Chief Medical Officer does not have control over the Chief Dental Officer or the Chief Nursing Officer, or the Chief Pharmacist. He has a general coordinating role with them; still less does he have control over the architects and the engineers.

The department runs nothing direct, except for three special hospitals for people guilty of crimes or unfit to plead, sent to hospitals because of their mental illness or mental handicap. It also has two separate agencies, a public health laboratory service board and a radiation protection service, each of which is run by an autonomous board funded by the health department. The department is headed by a Secretary of State, who is a politician, a Member of Parliament. In my time he has always been a member of the House of Commons, and because he has so much on which to answer questions in the House of Commons, I believe that this arrangement will continue. Under him he has the parallel administrative and medical hierarchy. There is a Permanent Secretary responsible for running the office; he has direct responsibility for the work in the health area. There is a second Permanent Secretary responsible for

administrative work on the social security side, and there is a Chief Medical Officer, ranking equally with a Secretary, who is responsible for ensuring that appropriate professional advice is provided to both sides of the department. The Chief Medical Officer's responsibility embraces both sides of the department. He has the right to go directly to the Secretary of State, and he cannot be overruled by his administrative colleague (neither can he overrule him), but I know of no difficulty arising from that. A sensible accommodation of differences is always possible between reasonable people.

There is also a Chief Scientist, who at the moment is a very distinguished former professor of medicine, and a separate research organization within the department, which also is related to both health and social security sides. The department is organized in groups of administrative divisions, each group under a Deputy Secretary, and each group matched by a group of medical divisions under a Deputy CMO which provide to their administrative opposite numbers the technical advice upon which much of the policy may be based. When appropriate, the other professional divisions, nursing, dentistry, pharmacy, are also matched with administrative divisions. There are about 7,000 staff members on the health side, and 85,000 in social security. The reason for the difference is that local work of the insurance and social security systems is undertaken by departmental staff. The health department staff is concerned only with guiding and influencing the work of the administrative bodies established outside. The social security side staff go out and do the local work, so there is an extensive, regional, departmental system. The total professional staff on both sides of the department numbers 1,500, of which about one-fourth are medical.

The combination of health and social security is recent, and there is not yet a great deal of pooling of resources within the department. Each of the Permanent Secretaries is an officer independently accounting to the government, which means that he is responsible for ensuring that the money voted by Parliament is spent in accordance with Parliament's mandate and not someone's whim.

There is one Chief Medical Officer who operates across the whole department and, as I said, the only professional services directly provided are for the provision of artificial limbs, and special hospitals for the mentally disturbed who must be detained in secure accommodations.

There are seven major blocks of work, each under a Deputy Secretary. One gives general administrative support to the office as a whole—the organization of the whole office—and deals with computer services and statistical services in support of both sides, research, the economic advisors, all establishment questions, and a central long-range planning unit. This block operates, therefore, across the whole department.

There is a services development group on the national health and personal social services side, divided up into eight divisions with particular functions attached to each. Three deal with special aspects of the health service, others the socially handicapped, the local authority social services, mental health, children (including the School Health Service), and medicines, food, and environmental health. Another group is responsible for the regional development of health and personal social services. Its staff is concerned with regional liaison; it provides the guidance required directly to the regional and area health authorities, and it deals with the capital program.

A fourth group is concerned with personnel questions of all the professions and the associated staff. There are two groups of divisions dealing with social security, and there is one common group of divisions managing finance—both health and social security. At present, the Deputy Secretary in charge of that group also is Accountant General for the health side.

There are regional and local offices for social security; and only small regional staffs for liaison on health and personal social services.

The purpose of my discussing this kind of development is to show how and why things have come together in this particular form.

The total cost of the National Health Service in the period 1974-75 was roughly $7.25 billion. The total cost of personal social services was $1.15 billion. In the health buildup, 6.2 percent goes for general medical services, that is, primary care, $445 million; general dental service, 4.6 percent, $320 million; the pharmaceutical services, 8.92 percent, $640 million; the opthalmic service, providing spectacles, 1.4 percent, $75 million; hospitals' current expenditure, 57.7 percent, $4,183 billion; and hospitals' capital, 8.15 percent, $590 million. The local authority personal social services account for 6.5 percent, $470 million of the combined health and social services total.

The percentages I have given you for the health services are percentages of the expenditure on health, not of the combined total. The funds for this expenditure derive 90 percent from taxation (again, this is for health), about 4 percent from users, and just under 6 percent from a fixed contribution from the National Insurance Fund total.

The proportion of British gross national product spent on health at the present time is 5.4 percent—which is a considerable increase over the previous year, when it was slightly in excess of 5 percent. This is mainly due to large increases in remuneration accorded staff at all levels during that particular financial year, and to a fall in GNP. It is not due to a 9 percent real increase in the expenditure on services; only about 1 percent increase was attributed to that.

I am afraid that the foregoing may have provided nothing more than some sort of historical understanding of how we in Britain came to the point we have reached. I have not attempted to deal in detail with the breakdown of function within the department, because I doubt it would be relevant to present American concerns; but if there is anything that you would like me to try and enlarge upon, I will be very happy to answer questions.

DR. LOIS K. COHEN: I was concerned, or rather, I am interested in the functions of the department, particularly if you could elaborate on the research role. You mentioned briefly that there is research operation dealing with the health sector under the social security function.

SIR GEORGE GODBER: There is a substantial expenditure on research. Much of it is in connection with the development of equipment, of computer methods, and the use of, for instance, dental materials. Part of it is concerned with studies on the effectiveness of the Health Service in various ways. I recall a study on the relative costs and clinical effectiveness of two different methods of treating varicose veins, for example, and also for the support of minor clinical research, which is done through the health authorities. They budget for it and obtain an allocation in accordance with the program that they foresee,

which is a means of helping the beginner in research—the man who thinks he sees something worth studying but does not go to the Medical Research Council for what seems a relatively minor thing. But this money can be spent on quite large undertakings. For instance, there is a unit engaged in epidemiological studies within the Health Service and the effectiveness of different methods of providing a particular kind of care, research based at the Clinical Research Centre at Northwick Park. The health department pays one-half the cost, and the Medical Research Council provides the other half.

Also, there was a large investigation of psychiatric care in the Camberwell, London, area, involving maintaining a special register. This was started as a piece of health department-supported research, later adopted by the Medical Research Council. There is also a unit for the study of drug dependency, supported partly by the Medical Research Council, partly by the department.

DR. COHEN: Then the department engages in direct research in-house, and jointly with the Medical Research Council supports research done either by the local authorities or by universities?

SIR GEORGE GODBER: It may support it jointly with the Research Council, or it may do it simply by allotting funds to health authorities or universities which have proposed suitable programs. The department does not do much in-house research in the health field, except on health economics, but it does more in-house in the social welfare field. All of this is under the guidance of a Chief Scientist who has advisory boards and committees that link up with the Medical Research Council.

THE DEVELOPMENT AND SCOPE OF GENERAL PRACTICE

DR. MILO D. LEAVITT: It is my pleasure once again to introduce Sir George Godber of the National Health Service of Britain. Today he is going to talk to us about The Development and Scope of General Practice in the United Kingdom. We feel the topic is particularly important, because the role of general practice in Britain has been such an important one; the keystone, really, in the development of the health system.

In view of what is now facing us in the United States it is felt that we should pay particular attention to the experience of our British kin. Similarly, because of American interest in preventive medicine and concern about the teaching of preventive medicine, and about the purveyors of the preventive practices that we hope to encourage and develop in this country, I think we have much to learn from what Sir George may tell us today.

SIR GEORGE GODBER: I am afraid that all of you must feel that I spend much time on history in each of the discussions that we are having. However, this is quite deliberate, because as I said at the beginning, one does not do anything suddenly new in organizing health services. One starts with what one has and makes it over gradually. Nothing else can be expected because one is dealing with members, ten of thousands of members of professions, many of whom are sure that their own present way is right, and one can only get the required kind of change by consent. It cannot be done by direction, and that means that it is always valuable to look at the way we got to where we are, rather than merely taking a photograph of the situation at the present time. So that is my excuse for always trying to put what we are doing in the perspective of the history of what we did.

Now, general practice is, of course, the original medicine. I suppose it was a kind of general practice that Hippocrates carried out; certainly it was the kind of practice recorded in Herodotus as having been undertaken by Democedes for the population of one of the Greek Islands for which he was each year paid a talent of silver. That was the original position, but as soon as one begins to make medicine more complex and more scientific—as we began doing, I suppose, 100 or 120 years ago—parts of it have to be carved out and become the province of particular individuals with special experience in depth. Ultimately, then, general practice is not the whole of medicine, but is defined by its relation to the other specialties.

Historically, in Britain, the first organized medicine was that of the Royal College of Physicians, which in the sixteenth century was an organization of physicians mainly centered on London. They were the lineal descendants of the best of the physicians in monastic times, not concerned with treating everybody, but concerned with the treatment of the relatively small number of people who came to them and who could afford to pay their fees. Separately, the barber surgeons developed the kind of activity which the physicians were, by their own statutes, prohibited from carrying out, and these barber surgeons

were incorporated not as a royal college in the sixteenth century, but as a city company in London. Incidentally, this Barbers' Company still exists.

In Scotland, on the other hand, one of the King James was himself interested in medicine, and it was he who helped establish the Royal College of Surgeons of Edinburgh well before the establishment of the Royal College of Surgeons at London. In the beginning of the following century, the other group, the apothecaries (who provided herbal remedies for sale to the public and gave a sort of lower level of medical care), were also incorporated as a city company—the Worshipful Society of Apothecaries—under a charter given by King James the First. The curious thing is that it was this third group that was the first to introduce any formal qualifying examination into medicine in Britain, because they set up examinations in 1816, about 30 years before the surgeons, and about 40 years before the physicians woke up and started asking for more formal assessment before qualification. But the physicians and the surgeons, accepting each other rather grudgingly on the one side, certainly did not accept the apothecaries on the other. They regarded this very lowly form of life as one that should be kept in order, and limited to selling drugs.

The apothecaries did not accept that limitation, and being supported by the first of the Stuart monarchs, where the Tudors had supported the other lot, they did get themselves established, although well into the eighteenth century they were still having arguments that sometimes led to actual fisticuffs. The conflict is very well described by Rosemary Stevens in her book, *Medical Practice in Modern Britain,* and it came to an end only after the registration of doctors (under the then newly-established General Medical Council) was introduced in 1856 by the first of the medical Acts.

I should also mention that in the very early stages the Archbishop of Canterbury had the right to confer a Doctorate of Medicine, and he did so, although I don't believe there have been any such doctorates conferred since about the seventeenth century.

At about this time, the specialties began to emerge around hospitals as they were first developed. Again, the very earliest hospitals followed on from the monasteries, one of the oldest of which was in Rochester in Kent. St. Bartholomew's and St. Thomas's compete for the honor of being the oldest in London; by their names they indicate their ecclesiastical origin.

In the major population centers, hospitals began to be set up. By the early part of this twentieth century they were staffed almost wholly by specialists and, although the staffs of those hospitals were closed staffs in the sense that the doctors in the area did not have hospital privileges, only the staff selected for the purpose by the managing bodies of the hospitals were given any facilities within them.

I was trained at the London Hospital, and even when I was a student, just over 40 years ago, there were still some people on the hospital staff who spent part of their time in general practice. They mostly were the anesthetists, because in the pecking order of the specialties, anesthesia was still a long way down at the bottom.

In smaller centers outside the main teaching centers, the hospitals had closed staffs, selected staffs; they were not places in which any physician in good standing had the right to practice, as was usually the position here in the United States, in the community hospitals, at least. But often the staffs of those hospitals, although they were selected and had some specialist training,

also did general practice outside. Often they had to establish themselves in general practice before they could become appointed to hospital staffs. I knew excellent surgeons who had to wait around for dead men's shoes for 15 years or more, while men of lower qualifications had the hospital privileges which they themselves lacked.

In the smaller towns in Britain there were also some hospitals, usually called cottage hospitals, which undertook the nursing of patients not requiring highly-specialized intervention, but in which a general practitioner, if he chose to undertake, shall we say, some radical surgery, could do so. The larger of these cottage hospitals would also usually have a weekly or fortnightly visit from one or two of the specialists from the nearest large center. Then, of course, there were the other hospital units such as those for infectious diseases, which were really for the isolation of patients, and were often very small, or the small infirmary units of what had been public assistance institutions which housed a number of elderly chronic sick. These patients usually were not expected to get better, and they did not get treatment that would help them to get better. Specially appointed general practitioners were generally responsible for the care of these patients.

I can recall two small towns in Derbyshire in which there were institutions of quite considerable size, each with a substantial infirmary or hospital component. In the early 1940's, the medical officers in each of those institutions had been preceded by their fathers, and they by their fathers, and these institutions, built in the 1830's, had never had medical staff from any other family. So those institutions were closed, too. Since they did not provide opportunities of adding to income, nobody minded very much.

However, there was a British Hospital Association, which was an association of voluntary hospitals run by charitable bodies, up until the National Health Service. By the late 1930's its policy was such that in all hospitals in membership of the Association, the staff was restricted to those selected. Automatic rights were not given to general practitioners in the area. When funds became available to the hospitals they might actually employ the doctors, but in virtually none of the hospitals—whether provided by public authorities or by volunteer bodies—did patients pay their doctors. It might be that the doctors had part-time or full-time salaries in local authority hospitals, but they had no fees from the patients, whether the hospitals were voluntary or public.

This meant that most doctors had no hospital privileges, and it also meant that patients were seen at hospitals only if they were referred there by their own doctors. This was one of the fundamental conditions for "peace" between the specialists and the generalists: that the specialists would be genuine consultants; they would receive patients only on reference.

When the National Health Service was introduced in 1948, this which had been professional custom became the service rule. At that time, though, some hospital staff members necessarily had been only part time in hospital service. For instance, in the Lincolnshire town of Grimsby, with a district population of more than 150,000, there were but two staff specialists restricting their practice to one specialty. Other surgeons on the staff did some general practice in order to live, because there just was not enough private specialist practice. But when the National Health Service was introduced, these people turned to their specialist activity and gave up general practice. Nearly all the general

practitioners who had hospital appointments at that time decided to go one way or the other. They decided either to give up their hospital privileges and concentrate on their general practice, or they decided to turn wholly to the specialist side of their practice.

The effect of the 1948 introduction of the Service was particularly conditioned by the settling of remuneration, and this settling of remuneration, on the advice of the Spens Committee, was favorable to the specialists and unfavorable to the general practitioners. The top of the specialist earnings was more than twice the top of what any general practitioner could expect to get, and the average of specialist earnings was well above the average of general practitioner earnings. In the beginning—and before the final settlement following the adjudication that after about 3 years gave justice to the general practitioners—the disparity was even greater. The average general practitioner was not even getting to the bottom of the consultant scale, and the man right at the top of consultant earnings was getting at least three times what any general practitioner could hope for.

The specialists, of course, regarded themselves as a superior kind of animal to the generalists at that time. There is no doubt that the highest quality of doctor in Britain at that time was represented by some of the most distinguished of the specialists, who made up the leading element in the Royal Colleges. However, there were a lot of other specialists who had been working at a somewhat lower level, and who yet were treated in exactly the same way in terms of salary scales. They often took unto themselves the aura of the distinguished figures in the Royal Colleges, and as a result assumed a somewhat distant attitude toward the general practitioners.

It will be appreciated that specialists previously had obtained their income only from fees paid by patients referred to them by general practitioners, and thus it was hardly profitable to be hoity-toity with general-practitioner colleagues. But when the greater part of the specialists' income was being paid as salary from the Health Service, the same considerations were not always applicable, and there was in the specialists a sharp increase in what the Greeks would call "hubris." And, incidentally, there was an increase in the number of very smart cars seen parked outside hospitals. Inadvertently, this change of attitude was expressed by one of the leaders of the specialists who had been a member of the Spens Committee on specialists' salary, the man who largely devised the system. He expressed the extreme consultant view that all medical students would start aspiring to the specialist's nirvana of becoming a consultant, and he actually said, in giving public evidence to a Royal Commission around about 1956, that all would compete in this way, and those who fell off the ladder would go into general practice. Now, one cannot get much higher in self-esteem than that, and it can be understood that, to the bulk of the profession, this was an unwelcome viewpoint.

The specialists did have more private practice, at least the well-established ones did. In the early days, the specialists were committing themselves to only about 7 half-days a week, which amounted to seven-elevenths of a full-time salary, from the National Health Service. This was to change fairly rapidly and the specialists moved up to maximum part time, which was nine-elevenths. In the early days a small number of specialists were getting a great deal more income from private practice; not only more than the average general practitioner, but probably in total much more than the total number of general

practitioners were getting from private practice. The fact of their being paid by the Health Service made some of them feel less concerned for the well-being of general practice, and this of course exacerbated the feelings of the general practitioners that the consultants were totally unmindful of the full professional interests. There was, for a time, a much deeper schism within the profession than we have had at any time since, and probably for 50 years before.

The hospital training posts, the posts for junior staff in hospitals, were not aligned toward training for general practice. They were arranged in a way that assumed that people would spend at least 1 year in hospital posts, but only some of them would go on to a second year of junior hospital posts, and then compete for a post for third and fourth years—many of them failing to achieve it. The survivors would compete again after 4 years of this kind of experience for a final 4-year training post, which eventually would get them to the dizzy heights of being hospital consultants.

All this was thought out by hospital specialists in terms of producing successors for themselves, just as teachers of Greek and Latin and other classic subjects think mainly of reproducing themselves in subsequent generations (although they might contest that). But obviously this was something that later had to be put right. The loss of hospital privileges that I mentioned, and the fact that some doctors who were on hospital staffs were not judged to be of full specialist quality and were not given appointments as consultants, affected only a few, but it was a blow to the prestige of general practitioners, and much more was made of it than actually the effect on individuals justified, because most of the best trained in specialties had turned wholly to hospital work.

The initial impact of 1948 on general practitioner work was that at least 95 percent of the population registered with general practitioners to receive service under the National Health Service. This meant that private general practice had almost disappeared right at the beginning of the Service; and of the 5 percent who didn't register, at least 2 or 3 percent were probably the people who forgot or didn't bother to do it until they became ill. It is thus unlikely that as many as 2 percent of the population were thinking in terms of getting their future medical care privately, instead of under the National Health Service. Previous national health insurance had covered only insured workers, and now dependents, married women and their children, were entitled to free care. Probably many of these dependents had not previously gone to their doctors when they should have, and now they started to do so. In consequence, there was a considerable increase in the demand on general practitioners which, according to one survey (and it is the only really reliable figure), by the second year of the National Health Service was running at about 12 percent overall.

The distribution of general practitioners wasn't as irregular as the distribution of specialists, because it had not depended wholly on private practice. It had been supported, to a considerable extent, by the national health insurance available to insured workers, but there was about one-half of the population not entitled to care under national health insurance. Many not entitled to care under national health insurance had paid private fees, even at the poorest levels, and many doctors rank sick clubs which were joined by people covered under national health insurance in order to obtain coverage for their wives and children.

In most parts of the country there were the relatively well-to-do, who were charged fees that made quite a substantial contribution to the total income of doctors. This meant that there were doctors distributed in large numbers where there were more well-to-do people; such as in, for example, a south coast town like Worthing, to which many well-to-do people would move on retirement. In retirement, with inflation threatening, such people immediately turned to the National Health Service for their care, and this led to the situation where in a town like that there were more doctors than would be able to get adequate remuneration simply from the National Health Service capitation fees. (The National Health Service at first paid its general practitioners on a flat rate capitation fee, without even an adjustment for age.)

So, suddenly the doctors in the industrialized areas with very large lists of patients—4,000 or more to a single doctor—became the affluent general practitioners, and those who had been proud and affluent private practitioners in areas where they were almost ashamed to admit that they had a small panel of national health insurance patients were suddenly very much the less well-to-do. The latter, in some cases, removed themselves to less salubrious areas where there were more patients and more capitation fees, but perhaps less social influence.

At the beginning of the Service, the upper limit of a general practitioner's patient list was 4,000. He could, if he hired an assistant, have another 2,500, and the average list for general practitioners in 1950 was 2,500—well above the level thought desirable as a national average today. There were many areas, industrial areas, where that average at the beginning of the Service was nearer 3,500. General practitioners were paid a capitation flat rate from a national pool calculated in accordance with the number of registered patients, so that the 2 percent or so of the population who had not bothered to register represented a serious loss for the general practitioners as a whole. However, because people tended to move from one area to another (and often to be counted twice for a year or two until their records caught up to them), the number of people for whom contributions were paid into the national pool was, after a while, more than the number of people living in the country. The national pool had so much per head for every person at risk placed into it, and then an addition (at that time 34 percent) representing the average ascertained cost of practice. This cost, determined from income-tax returns, represented the average of practice expenses. But a doctor who provided really good consulting-room facilities and had suitable supporting secretarial and other staff could have been paying more than the 34 percent, enough perhaps to have justified an additional 50 percent. And conversely, one who practiced in a heavily-populated, poor area from a sort of lockup, store-front shop might have had a full list and practice expenses of but 10 or 15 percent. These disparities were not taken into account when distribution was made; the distribution was made equally in accordance with the size of doctors' lists of patients registered with them over the whole country, and it was grossly unfair.

In that situation there was no incentive to take partners, because if one took a partner, one simply reduced not only one's own income, but the average income of all general practitioners. Therefore it was much more profitable to general practice as a whole to have assistants, rather than partners. Thus there were, for perhaps 17,000 general practitioners, 2,500 assistants in England and Wales.

At the beginning of the Service, the National Health Service Act removed the right to sell the goodwill of a practice. In place of this right a compensation fund was set up, from which the general practitioner would be able to have his share when he retired. This fund originally amounted to something like (if I remember correctly) £66 million, which in 1948 looked quite a lot to be distributed among some 16,500 entitled general practitioners plus nearly 2,000 in Scotland. Ten years later it looked very different, when inflation had substantially reduced the real value of the compensation. The fund was not finally disbursed until 20 years later, so in the interim, although interest had been paid on the sum due, the capital sum had seriously depreciated. Therefore, compensation for the right to sell one's practice was by no means generous by the time it had all been repaid.

Prior to 1948, recruitment to practice had been by the doctor himself. He might have written to his own medical school to get a successor. He might advertise to sell his practice, with perhaps 2-1/2 years' net income as its price, enabling him to choose his successor having more regard to the person willing to pay the maximum price of the practice.

During our previous discussion I mentioned a gross though atypical example of two partners who unwittingly sold their practice to an alcoholic who, in fact, died of alcoholism within a year. For this year he practiced in an isolated small town with only one young doctor as a salaried assistant. That was the sort of situation that simply could not continue within a National Health Service, when most of the goodwill of the practice was the list of patients for whom fees were being paid under the National Health Service. So a new system was introduced, whereby in under-doctored areas it was possible for any individual to set himself up in practice. He could buy premises and put up a plate, and wait for patients to come. Incidentally, all doctors who had registered their intention to practice by the appointed day in July 1948 were admitted to National Health Service practice.

But at the other end of the scale there were areas in which there were too many doctors, and there was a large intermediate area where selectivity in recruitment could be allowed. A Medical Practices Committee, operating at the center, consisting wholly of general practitioners, and with a salaried chairman who was himself a general practitioner, defined the areas to be regarded as over-doctored or under-doctored or intermediate. The Committee accepted all applicants in over-doctored areas, whether an existing practice was vacant or not. They accepted no new applicants to practice in an under-doctored area, even if a doctor wanted to take on an additional partner who could later succeed him; and they allowed no assistants in those areas either. In intermediate areas, which were the majority, they chose people who were to be admitted to practice from among applicants responding to advertisements.

Because of the nature of the renumeration pool, during the first 3 years there were few attempts to increase the number of general practitioners. But the 1952 adjudication, which finally gave just treatment to the general practitioners, determined that the size of the pool in future was to be based not upon the number of people who wanted to use the medical services, but upon the number of doctors. The argument was that there were too few doctors (which by common consent was true), and that additional doctors therefore would only go some way toward reducing the overwork of existing

doctors to an acceptable level. A larger number of practitioners should share in a proportionately larger pool.

When patients had registered with doctors, the patients were remarkably loyal. They tended to stay with them so long as they lived in the area, except occasionally where a sharp disagreement would occur between doctor and his patient, or between a family member of the patient. The patient turnover in practices in the course of a year was remarkably small. I cannot provide an exact figure, but an assessment is that less than 10 percent of the people in a practice would move on in the course of a year (and, of course, that 10 percent could be the same 10 percent each year). A practice could well have 60 to 70 percent permanent members, depending on the area. It would be in the remaining 30 percent or so that the change was occurring, and this would occur quite naturally from children growing up and moving away, a daughter marrying and living in another area, or perhaps not living in another area, but choosing to take the same family doctor as her husband.

Therefore, a newcomer trying to set up practice even in an over-doctored area would not quickly recruit patients sufficient to give him a proper income—unless he happened to set up practice in a large new housing area, where there was nobody else within reach. That is the way in which quite a number of new practices were established in the new towns and in large housing extensions of existing towns in the early years.

Patients had freedom to choose. They did not have to select the doctor who lived on the same road. They could choose one within any reasonable distance, and they simply went and registered with him if he was prepared to accept them. Thereafter, if they decided they wanted to change, they could do so at once if the doctor agreed, but if he disagreed with their changing and did not like to lose them, they could nonetheless go at their own wish after a period which was at first 3 months. A doctor could also give his patient 3 months' notice of his wish to remove the patient from his list, and that 3 months' interval was later reduced to 1 month. (One can imagine the sort of circumstances in which a professional relationship could no longer be maintained between two people in disagreement.) A patient who had not chosen a doctor could go to the Executive Council that ran the Service and ask to be allotted to a doctor, and the area's, county's or city's general practitioners accepted a collective responsibility for the whole population. In an emergency, if a patient was away from home, he could go to any doctor in the National Health Service and obtain emergency treatment, and the doctor would then be paid a special fee which came from the same renumeration pool.

A doctor in the Service was paid a capitation fee, whether he saw the patient or not, and the fee remained the same, irrespective of how many times he would see his patient. The average number of doctor services at that time was thought to be 4 to 4 1/2 per patient per year, but there were at least 30 percent of patients who did not visit their doctors at all; thus the average consultation by the people who did see doctors was somewhere between 5 and 6.

The quality of care provided in general practice at that stage was widely variable in different parts of the country. An Australian, F.S. Collings, wrote a sharply critical report in 1950. He was not always critical on the right grounds. I had some discussion with him at the time of his survey, and it was very clear that he was looking for defects. Well, that is legitimate, but if one looks for

defects in any service of that kind, one will certainly find them, and he made the most of the worst conditions that he found. One of his criticisms was that in all of the practices he visited, in only one was a microscope in use. However, he missed the point that the British practitioners, unlike some in the much more thinly populated Australia, had hospital laboratories close at hand, and there was no need for them to be looking down microscopes, when within easy reach of them were people more expert to do that for them. A general practitioner need not do his own red-cell counts or white-cell differential counts, in the conditions of general practice. I mention this simply to be set off against his very critical report. At the same time, Dr. Hadfield of the British Medical Association and Dr. Stephen Taylor (who later became Lord Taylor, Vice Chancellor of the University of Newfoundland) wrote reports on general practice that were more moderate and much more helpful. Both accepted that among general practitioners there was a minority, somewhere between 5 and 10 percent, the quality of whose practice was certainly below what one would regard as an acceptable level.

General practitioners were, of course, independent contractors. There was no system of control over them in the absence of complaint, except a requirement that they should be available to consult at hours that they had to record with the Executive Council with whom they had their contract. It was therefore extremely difficult to intervene, even where it was common knowledge that a general practitioner was providing less than the desirable level of service—unless a patient complained. A patient could complain to the Executive Council, the Executive Council then had to investigate the complaint through a special service committee, only half of it professional, before which any serious complaint would go. (Which means, really, any complaint that the patient was not prepared to withdraw.) If a doctor was found at fault—and some were on such grounds as failing to visit on request a patient who was ill, and whose condition required a visit—the doctor could be reprimanded or some of his remuneration could be withheld. These cases had to be reported to the Minister, and in the event of a withholding being recommended, this would be reviewed by a central committee. In an extreme case, the Executive Council could seek the removal of the doctor from their list, and for this were required to present a case to a special tribunal. During the existence of the National Health Service, fewer than 30 such cases have been considered, and in the first 2 years, only one doctor's name was recommended for removal from the list.

This shows that the complaints machinery was not easy to operate—but on the other hand there was no machinery for the doctor to complain, and although a doctor could give notice that he wanted a patient removed from his list, there was no way in which the patient could be disciplined for a gross abuse of the service. It is interesting to note that the USSR introduced a law providing for a patient being sent to jail for unreasonably abusing his doctor. Doctors have often asked for some such power in Britain, but I am afraid it is—no, I am not afraid—I am entirely satisfied that it was never conceded to them, because if a doctor is a sound doctor with good relations with his patients, he can deal with anybody really recalcitrant, and he always has the possibility of refusing to continue in a professional relationship with that patient.

The range of care expected to be covered in general practice was virtually all care, short of that requiring specialist intervention, and the referral of any

patient needing specialist attention (and indeed, not only to a specialist; perhaps calling for the service of a home nurse, or referring the patient seeking a home confinement to a midwife to take part also in the home care, or even reference to the social services). One of the commonest services outside the range of practice that people were apt to ask of their doctor was to sign their forms for getting passports, because doctors were allowed to do that.

But how does the patient begin to use the Service? He is registered with a doctor. He simply goes along to see the doctor at a time when the doctor has consulting sessions in his office, or if he is sick at home, the doctor can be asked to visit him, and the doctor is expected to visit him if the patient's condition requires it. He is not expected to visit if the patient has a condition that could be attended to in the doctor's office, but the doctor is seldom prepared to take the chance involved in thinking that perhaps it really does not matter this time. After all, a child, febrile, in bed at home could have anything from a tooth erupting, needing no treatment, to a surgical abdominal emergency, or an otitis media with a drum about to perforate. The number of attendances estimated from a household survey was between 4-1/2 and 5-1/2 per person on the list per year, but the range was probably from 2 to 8. A survey conducted in the middle 1950's by Logan and Cushion gave that sort of variation between some 150 practices, and similar figures were obtained by Logan and Forsythe from a local survey in the town of Barrow-in-Furness in northwestern England.

About one-third of the calls on doctors at that time were for visits, and the further north one went, there was not only a higher ratio of office calls by patients, but a higher proportion of home visits. The proportion of home visits throughout the country has fallen since the beginning of the Service, because as we all know, the acute infective episode has become a much smaller part of general practice, and most of the conditions for which doctors are now consulted are long-term conditions requiring support and maintenance therapy, rather than the acute episode, which may be life-saving.

Referral to hospital, which some specialists were alleged to believe was the only thing the general practitioner ever did, was not nearly so commonly resorted to as the specialists sometimes suggested. Even by 1972, the rate of referral of new outpatients to hospital was only 171 per thousand of the population. It did increase substantially in the period after the inception of the Health Service, but one would expect that, remembering how much more extensive specialist services have become, and how much more outpatient service has been used for psychiatric illness and, for instance, for geriatric patients. But in the last decade, there has been an increase of 8 percent when the population increased by only 2.6 percent. The main areas of increase are in traumatic and orthopedic surgery, in gynecology, in child psychiatry, in geriatrics, in some of the new specialties, and in venereal disease (which we know perfectly well has doubled in that time in Britain, as in most other countries apart from the People's Republic of China).

Unreferred patients could go direct to hospital accident and emergency departments and might do so in a real emergency occurring when they were away from home, or occasionally because their general practitioner was not readily available, perhaps late in the evening. The increase which has occurred there is from 129 per thousand population to 173 per thousand during the last 10 years, so you will see there has been an appreciable use of accident and emergency departments. That might be partly the result of consultation of a

general practitioner who, maybe using appointment systems, is not so readily available as in earlier years. But the total of attendances at accident and emergency departments amounts to only about 5 percent of attendances by patients on general practitioners, and is a small component in primary care, much of it justified by genuine emergency.

The total ambulatory or domiciliary care, including attendance at consultative outpatient sessions, might amount to between five and six a year in the ratio of five attendances on a general practitioner to one ambulatory attendance on a hospital.

General practitioners have available diagnostic services from the hospital, as follows. First, the outpatient consultation with a specialist on reference, followed by perhaps three further attendances during further investigation of the patient (though that ratio is falling because the patients are normally referred back with a recommendation to the general practitioner). Such recommendations can include notice that the patient will be admitted from the waiting list as soon as a bed is available.

Pathology and radiology services are available to general practitioners' patients direct on request, and this use by general practitioners has, in the last 10 years, increased to the point where general practitioners are using about one-eighth of pathology facilities, and one-tenth of radiology facilities—as compared with one-seventeenth and one-eleventh 10 years ago—so there is a substantial use of diagnostic services. This is reasonable use, not excessive use; a good deal less, probably, than by young junior hospital staff in hospitals. An increasing proportion of general practitioners can also get electrocardiography done for them at hospital. Some of them prefer to own their own electrocardiographs and if they have not used the hospital services they can always get a cardiologist's view on their own tracings.

Also there are facilities for consultants to be called to patients in their own homes, and the average general practitioner makes use of that service about 15 times a year. This use is by no means excessive; such visits are for patients unable to attend hospital outpatient departments.

All of these resources available to the general practitioner from the hospital have developed and improved with time, but in principle they were present or anticipated from the beginning.

Several analyses of general practitioners' work have been done by Logan and Cushion, as already mentioned, and by the Royal College of General Practitioners working with the Office of Population, Censuses and Surveys.

The majority of calls on general practitioners are for relatively minor, short episodes, and for some psychosomatic conditions; but in the average practice major episodes would include eight or nine cancers a year and as many cases of acute appendicitis. There will be rather more cases of myocardial infarction; 30 times as many cases of lower respiratory infection; eight or nine patients might come with mental illness requiring hospital admission, which will be just as urgent as any acute abdominal surgical episode.

In the average practice up to 40 patients will have new pregnancies in a year, and five will have wanted abortions. Many more patients will be seen frequently for supportive and continuing care of, for instance, arthritis, chronic respiratory or cardiovascular disease, or diabetes. In the average practice, there will probably be 15 patients suffering from diabetes.

One only has to think about conditions like hypertensive disease and depressive illness on maintenance medication to realize how important is the continuity of care provided by general practice, and the range surely is as wide as anyone would want. But general practice has to be seen as linked with and backed by the resources of secondary hospital care; and the tertiary level of care.

Provision also has to be made for continuing postgraduate medical education for general practitioners, and time within general practice is necessary for that. A Royal College of General Practitioners' survey estimated that the average practitioner spent around 40 hours a week in contact with patients. The figure includes some traveling time during visiting, and possibly some writing of letters about patients to specialists. But any general practitioner, any doctor, has to spend a great many more hours in maintaining his professional knowledge and this has got to be allowed for in the total burden on the general practitioner, and I believe that a good general practitioner has a pretty heavy week's work, one way or another.

The organization of practice has changed substantially, particularly during the last dozen years. This change was first prompted by the increased remuneration in 1952, retrospective to 1948. The increase awarded to general practitioners was so large that it was possible to adjust the distribution of income of general practitioners without anyone failing to get some increase—and that is very important when it is necessary to negotiate something which does not give equal shares to everyone. After that adjudication, the flat-rate capitation was changed so as to give a relatively higher return to physicians with intermediate-sized lists. People with lists of less than 1,000 patients continued at the standard rate of capitation, but for doctors with patients numbering between 1,000 and 2,500 the rate of capitation was raised. For a doctor with patients in excess of 2,750, there was reversion to the basic level of capitation, so that for a medium-sized list a physician was being paid more per patient than if he had a full list of 3,600—because following that negotiation the maximum size of a list was cut by 10 percent.

Initial practice allowances were introduced to help establish doctors in under-doctored areas, and the important contribution of £100,000 a year that I mentioned in an earlier discussion was made to a fund for providing interest-free loans for group practice premises. At that time, doctors were unwilling to go into health centers, but they were willing to move into group practices of their own making, and that is where the interest-free loan system was so important. One-half of all doctors were single-handed in 1948, and very often the partnerships consisted only of a financial arrangement, with no real combination of the practice. But today only about one doctor in six is in single-handed practice, and some of those have moved into health centers, so that in effect they get many of the benefits of group practice.

There was another advantage to group practice, in that it was much easier to work with the community nursing staff. It was less complicated to attach a nurse to a practice where she could work with three or four doctors—because there were and are many more doctors than home nurses in the British setup—than to get one nurse to work in a similar association with three or four separate practices. The first two attachments of public health nurses were achieved in 1954, and the arrangement slowly extended until the early 1960's.

Thereafter it was generally accepted, and is now the way in which most general practitioners and most community nursing staff are working.

At that time, remuneration was simply a matter of negotiation between the departments' representatives and the profession, and departments' health departments with treasuries behind them, are seldom ready to accept that professionals' claims for remuneration are fully justified – they may not be. The situation grew so embittered, that in the late 1950's doctors were talking about withdrawing from the Service. They were dissuaded, however, and accepted that a Royal Commission would be appointed by the government to recommend the future pattern of doctors' remuneration. Now, a Royal Commission can be a commission to do something, or it can be a convenient way of putting some inconvenient subject on a high shelf, away from anybody's notice, but this one did something, it produced a series of recommendations that still largely determine the way in which doctors, whether in hospitals or general practice, are paid.

The commission first of all recommended that doctors' remuneration should be increased, and by almost as large a portion as they had been asking. It pointed to the evidence given by the profession at the earlier adjudication by a judge, suggesting that their position relative to other professions ought to be maintained, and said that this was the right basis for the future remuneration of doctors, rather than a kind of commercial bargaining between the department and the profession in which doctors would tend to drift down the scale. It recommended that they should keep their place relative to other people, and particularly to other professions and it proposed scales to do this. It recommended that an independent review body should be set up to advise the government in future on the levels of remuneration for doctors in all forms of practice. This was subsequently set up. The commission also said that the government should stop expecting doctors to provide the money for group practice loans, that the money should be repaid, and that instead the Treasury should provide the money for this purpose.

All this was accepted by both the profession and the government. But in general practice there remained an underlying factor which went on to produce increasing discontent, this was the system of payment through the remuneration pool with a fixed proportion for expenses, which I have already described. The discontent stemmed from the fact that the fixed proportion meant that the man with a long list, who chose to give little attention to facilities for practice and assistance in his practice, would be financially better off than the man who really did his best to provide a good service.

So in 1964-65 we again came to the brink of an open breach. Fresh negotiations (not left to the review body) about the method of remuneration rather than the quantum were undertaken directly between the health departments led by the Minister, then Mr. Kenneth Robinson, and the representatives of the profession, this led to an agreement described as the General Practitioner's Charter.

The argument that doctors should be paid by realistic fees per service, which some of them wanted, was not accepted. We kept the capitation basis of payment as the main source, and we agreed not to part-time salary (which Mr. Bevan had wanted to introduce in 1948), but to an annual payment, which is called a basic practice allowance and is paid quarterly or monthly, as the doctor wishes.

In order to give some progression to doctors' salaries, seniority payments were also allowed in three steps at 10-year intervals. A supplementary payment was introduced for recognized vocational training before entrance into general practice (a new entrant into general practice would not, of course, be entitled to a seniority payment for 10 years). New entrants with formal training for general practice were given an allowance which brought them part way to the first seniority payment; and this has since been increased.

Another real injustice was corrected. Doctors who had been expected to provide premises were now to be entitled to a nominal rent for the premises, the actual amount being assessed on the premises they provided. If they worked in a health center, this rent allowance would be related to what was charged for the use of their health center premises. Thus, the handicap of having to pay a high rent for ad hoc premises was removed, and the main obstacle to doctors going into health centers was also removed.

A special allowance was also included, added to the basic practice allowance, for undertaking to give care through the night. Now, this is really a bit fictional, because nobody really undertakes to do both general practice between the hours of 7:00 a.m. and 11:00 p.m. and let somebody else look after his patients in the middle of the night. It does happen in the emergency arrangements made in Copenhagen, but the responsibility is, in theory, paid for separately and at a higher rate. There were also additional fees for night calls, which in fact are very few. The average general practitioner gets about two night calls in 3 weeks; it is not a really heavy burden, and even that number tends to be falling.

Small fees were also to be paid for certain preventive work regarded as public policy, this work having been accepted by the Health Department as necessary. Included were immunizations against diphtheria, tetanus, poliomyelitis, pertussis, measles, and rubella in girls. All these would attract fees for the immunization, if done, and if a record was returned—but not, for instance, for the use of influenza vaccine which was not generally recommended as public policy.

Fees could be paid for doing cervical smears, but only in age groups for which general screening was public policy; that is, women aged over 35, and younger women who had three or more children.

A public corporation was set up to provide an alternative source to government of financing improvement of practice premises, and currently the General Practice Loans Corporation lends £2.5 million to 217 groups to improve their practice premises. That was the amount advanced in 1973-74.

The outcome of all this was to give general practitioners a level of remuneration well within the range for consultants in hospitals and to make health centers an economic proposition. In the first 15 years of the Health Service, only 17 health centers were built, now about 100 are being provided each year. Today, more than four-fifths of all general practitioners are in groups or in health centers. There has been a large increase in the number of ancillary staff employed in general practice, secretarial and other; and through other means, nursing staff in the community are nearly all associated with general medical practice.

As a result there is a great deal better organization of groups in practice: This permits more certain off-duty times and regular vacation periods, groups also facilitate the economic use of ancillary staff. Four to six doctors practicing

together will be able to employ better quality secretarial staff than a single-handed practitioner. Deputizing arrangements are possible since members of a group practice may deputize for each other, and so get to know the patients of others in the group. Group practice allows for the development of appointments systems and more than 80 percent of all general practitioners now consult in their offices on an appointments basis, not the "come and wait" system of earlier days.

Group practice makes much easier the use of laboratory services in an increasing number of hospital areas; for instance, specimens for laboratory examination may be collected from group practices, a facility far less feasible when all are in single-handed practice. There can be the joint use of electrocardiography facilities in the group practice, and this also facilitates the provision of well-baby clinics, or organized antenatal clinics for the whole group. But many doctors (about 25 percent of all general practitioners) are using outside deputizing services similar to those of Copenhagen, in which an organized service will provide a deputy in the middle of the night to go to an emergency call, or on a weekend. This latter is, however, a threat to continuity, which should be the main advantage to be gained from the British type of general practice.

This sort of practice organization has fitted in with the improved educational arrangements for general practice. It is easier to organize vocational training for general practice, because some part of that vocational training should take place in good groups, and recognized group practices are usually used in university vocational training schemes. Individual members of groups are able to be absent from their practice for special refresher courses. The improved educational arrangements for vocational training are now so far developed that by 1980 all new general practice entrants may be required to have had systematic vocational training.

About 1,500 programs for trainees exist today, and greatly improved arrangements have been made for giving medical students first-hand experience of work in general practice. This year we have a report from a committee chaired by Sir Alec Memson on future regulation of the profession; it recommends that the General Medical Council, which now controls provisional registration and full registration after the compulsory intern year, should also undertake specialist registration. The Committee recommends that registration shall include general practice, as well as the hospital specialties. Under the present arrangements, the ongoing education of general practitioners is paid for by the Health Service, and the arrangements described in previous talks have ensured that such facilities are available to every general practitioner.

There is now a minimum requirement of attendance for ongoing education. Thus far it is insufficient; it is a requirement of five sessions (a session is one-half of a day) a year for the 5 years preceding the completion of the period which entitles a doctor to seniority payments. It means that if a man receives a seniority payment after 10 years in general practice as part of his future remuneration, he must have averaged at least five sessions a year in postgraduate education over the 5-year period preceding his entitlement. Most of them, of course, average a great deal more than that.

The district relationship to specialists, mentioned in our previous session, although not yet fully developed, is certainly greatly improved as a result of the provision of postgraduate medical institutes at the District General

Hospital in every district. It could go a great deal further. For instance, clinical pharmacology is an underdeveloped specialty in Britain, and undoubtedly the best use of drugs in practice is not always obtained. In Britain more than 100,000 patients are admitted to hospital each year for adverse reactions to drugs. Some of those are due to idiosyncracy, some to deliberate overdose, but some are due to the unwise use of potent drugs under medical advice. After all, with some potent drugs that we use now, the margin of error is very narrow. I would look to the further development of postgraduate education to reduce this, and particularly to further development of the specialty of clinical pharmacology as one upon which general practitioners are likely to make most demands.

One of the most important influences in improving the quality of general practice has been the Royal College of General Practitioners. Undoubtedly the establishment in 1952 of that body, and the recognition by conferment of a royal charter when it had been in existence for only 18 years, has been an important factor in reviving morale, which had sunk low in the early years of the Service. It has been concerned with establishing standards of education for general practice. It has been the guiding force in developing research in general practice and organizing special studies in both the organization of practice and scientific medicine—for instance, the studies on the oral contraceptives and research on the use of some of the other more potent drugs in general practice, and in studying education in and for general practice.

The College has had for the past 20 years a Medical Recording Service which provides tape-slide packs of recorded talks on a wide variety of medical subjects, illustrated by slides, available to groups of doctors or to individual doctors, anywhere in Britain and abroad. Since I came here I have heard that the Foundation has had an order for £2,000 worth of tape-slide packs from Libya, so the word goes quite a long way overseas. The College is not, of course, universal, but it does have in membership about one-third of the principals in general practice at the present time.

I would like to say in summary that British general practice at its best provides highly satisfactory primary and continuing care, and I would emphasize that the continuity is even more important than the availability of primary care. At its best, it is at a level satisfying to both patients and doctors, and to their colleagues in the hospital. Continuity is its best asset, but it needs improvement of the links with the hospital team.

At its worst, British general practice is probably as bad as any other general practice, but at least the body of general practitioners know where they are trying to go. I was quite surprised to learn from my colleagues in the European Economic Community that British general practice has a sense of direction, less readily evident in general practice in 7 of the 8 other countries in the EEC's 9, and it has the kind of incentives built into it that I believe will maintain a really high quality of general practice in Britain. I also am sure that under present arrangements, the Health Service in Britain will not be of high quality—unless we maintain and further improve general practice, which really carries the Health Service.

DR. MILO D. LEAVITT: Thank you for that comprehensive review. Are there any questions to Sir George?

DR. THOMAS D. DUBLIN: I hope that Sir George, in one of his later lectures (I know it is perhaps late in the day, and he has done a most exquisite job of coverage of a very complex and difficult parameter of the British health care system), will reflect the impact of European Economic Community agreement to share health-care services and personnel. This, to me, is a very challenging and interesting problem, because although there are certain economic similarities between the members of the medical community, I think there are disparities in terms of their concepts of health care.

SIR GEORGE GODBER: But you know, we have not agreed to share health care in quite that sense, Tom. We have agreed to freedom of movement within the medical profession. We have arrangements under which we must provide the same care for nationals of other EEC countries in Britain, as we provide for our own, which in fact we would have been doing anyway. The only impact I can see specifically from the EEC would be that a doctor from, say, Italy could come and set up in practice in, say, Bedford, England, where there are many Italian workers in the brick fields, and they might go to him because he spoke their language. He would have great difficulty in practicing unless his English was good, because he would also have to take English-speaking patients and indeed he would not get established unless he was English-speaking. He would have to sit and wait for people to come to him. If his opposition consists of groups of doctors working in well-established health centers, he is not likely to pick up the kind of practice that would give him a good income. I do not believe that Britain is going to be flooded by doctors coming from EEC countries to work in the NHS, neither do I believe that EEC countries are going to be flooded with British doctors, refugees from the British National Health Service. I don't think it is going to make a great deal of difference.

DR. MAUREEN HARRIS: Can you tell me why enrollment was so rapid in 1948, and why weren't doctors at all suspicious of this new system?

SIR GEORGE GODBER: I think that everybody had been anticipating a National Health Service. Most people wanted to see one, and I just think it was part of the general pattern of thinking of the British public at that time. They found that they could go to the man who had been their own doctor previously without having to pay him fees in future. Well, it is not surprising that people took up that kind of bargain. You see, the same health Service that Britain used on July 4 was still used on July 5, 1948; the change was in the method of payment. Since it was being paid for other than at the time of use and it was known that it was going to have to be paid for anyway out of income tax very few people chose to go and pay extra and continue to pay the doctor privately. My parents, for instance, went to the same doctor and paid him privately. But others in my family went to him, having previously been private patients, as National Health Service patients, and there was no business of doctors saying, "No, we want you to come to us privately." I believe that people were expecting it and that it was not surprising at all.

DR. STUART SCHWEITZER: If you have solved the continuing problem which we have in the United States of a substantial minority of patients seeking primary care through the irregular sources of hospital emergency rooms

and that sort of thing, if you have done that, if your poor or less medically-sophisticated do seek primary care through the normal channels, why is that? How have you been able to do it?

SIR GEORGE GODBER. A hospital emergency room physician, seeing a patient who says, "I've got a cough and want some medicine," would say to him, "You have a doctor. You should go to him." If someone walks in and says, "I have a very severe pain in my chest," he is smartly put down on a couch, if a coronary thrombosis is suspected; he is not told: "Go to your own doctor." There has not been a great tendency to use this service because it might perhaps be thought to be better—I don't believe it would be considered as better. It might sometimes be convenient, but usage of that kind is very small. However, if one were at work in central London and lived somewhere out in the suburbs and had sustained an injury to a hand that, in normal circumstances, would have been dealt with by one's own doctor, and there is a hospital down the road, one would go to the emergency room—and that is fair enough. Stitches may be needed; the hospital would put them in, and they would have better facilities than one's own doctor for doing it. But a patient would not be welcome at the emergency room with a statement such as, "Look, I've got a cold and I don't want to bother with my doctor." The hospital people would be tempted to say, "Well, you go to him." It is a matter for discretion, but people expect to go to their own doctor.

DR. DEREK GILL: Do you ever see any likelihood of Professor McKeown's specialties emerging into a practice?

SIR GEORGE GODBER: No. Tom McKeown is one of the few people in Britain who floats that theory, whereas I believe it would interrupt continuity of care. It is the sort of thing that one would see in the USSR, where a mother will go to the doctor in one public clinic, but take her young child to the pediatrician in another public clinic. The gain in continuity of knowledge of the family in handling all illnesses that are within the range of a good general practitioner is great and would be sacrificed by having several separate specialties within general practice. This would also almost necessarily reduce the accessibility. Sometimes one encounters the sort of practice in which maybe there are two doctors, man and wife, and the wife may have special experience in obstetrics or pediatrics, and by agreement among them she may look after the antenatal clinic of their joint practice, or she may have a well-baby clinic or an arrangement well understood by the patients concerned—but the babies that belong to her husband's part of the practice will not, as it were, bring the rest of the family over to hers. I believe there may be some minor changes of that kind. Also, someone will have a special interest in, say, cardiology, so he gets a part-time—perhaps a couple of half days a week—appointment as a clinical assistant in the hospital cardiology department. Thus, when he is back working in the practice, it is only natural for his colleagues in the practice to show him their electrocardiographic tracings, if they have them, or even get him to make them. One gets that sort of thing, but not the exclusivity of the specialist practice that grows up in the hospital.

THE RELATIONSHIP BETWEEN SOCIAL WELFARE SERVICES AND HEALTH SERVICES

DR. MILO D. LEAVITT: Sir George is going to discuss with us this afternoon The Relationship Between Social Welfare Services and Health Services. We believe that this is an interesting relationship, and I believe all of us will be very interested, Sir George, to learn just how you handled this particular relationship.

SIR GEORGE GODBER: Thank you, Dave. I believe one must start with the fact that health services usually are part of the general pattern of social services. The French recognize that by their concept of the social budget, which includes not only health service expenditure, but also expenditure on education, Social Security, personal social services, and assisted housing.

Health takes up about one-fourth of the French social budget. As usual, of course, international comparisons are complicated by considerable uncertainty about the definitions that people in different countries use for the particular components. Rudolph Klein, whose book *Inflation and Priorities* I have mentioned here before, gives the percentage of public expenditure in Britain for different purposes as education, 13 percent; Social Security benefits, that is cash payments, 17.25 percent; housing, 7 percent; personal social services, 1.6 percent; and National Health Service, 9.4 percent. There are a few other items, such as school milk and meals, and welfare food, which clearly are part of the social budget; and some like libraries and museums and art and research, which are arguably so, but altogether they amount only to another 1.4 percent. The budgets of all those services have increased substantially in real terms in the last 20 years, but health has increased less than all the rest I have named except housing. Only defense and agriculture now have a smaller share in the increase.

The largest growth rate of all is for personal social services, especially in the 5 years up to 1973. But that is partly due to the fact that the amount being spent on identifiable separate personal social services before the Seebohm Report was relatively small. Expenditure on education has increased at twice the rate of National Health Service expenditure, and cash benefits for Social Security by about one-sixth more than the National Health Service. The cost of Social Security cash benefits, of course, would have increased substantially in 20 years anyway, merely in order to meet the needs from the rapidly increasing numbers of dependent older people.

The total cost in 1974-75 for England was £553 million for personal social services, £3.44 billion for the National Health Service and the Central Administration, and a considerably larger figure for social security benefits. The payments for Social Security cash benefits are made on rates determined by the government and are regularly reviewed. They are supplemented by discretionary payments to meet particular cases of hardship. The standard benefits, including retirement pensions, industrial injury benefits, widow's benefits, maternity benefits, unemployment benefits and sickness benefits, all cash payments, are based on insurance deducted from wages and salaries—from everyone's wages and salaries.

By far the largest component is retirement benefit, which is currently being paid to about 8 million people. Noncontributory invalid pensions and, in special circumstances, invalid care allowances can also be paid, and supplementary benefits are at present paid to about 2.75 million persons. Family income supplements for those with incomes below the minimum, even though there may be an earner in the family, are paid to about 70,000 families. These supplements can be paid in cases of need from central funds; they are not insurance-related.

The effect of these arrangements is that central government, through local offices of the Department of Health and Social Security, provides the cash payments needed in the British Social Security system. The arrangement replaced the old system of outdoor relief of the indigent based on the Poor Law and its successor, Public Assistance, maintained by local authorities and brought together with the insurance system and central revenue. All cash payments, therefore, come from central sources. No cash payments are made from local taxation. The total cost represents the largest single component, more than one-sixth of public expenditure in Britain. Regarding my references to the Poor Law; in case there is doubt about what the Poor Law was, I mention that it goes back 400 years to a law enacted in the time of Elizabeth I putting responsibility on parishes for the maintenance and support of the indigent. Although it was modified appreciably, of course, over the years, and its administration eventually transferred to the larger local authorities, in essence it remained the same—not cash benefits but support by way of services and shelter.

The payments are part of the national system of social support, support that can be given in cash for some purposes from the central sources or insurance, or given locally in service. Under the system a special allowance can, for example, be made to an elderly person for fuel in winter, rather than ensuring that the heating of that person's domicile be undertaken through a local service. Every year we have a certain number of deaths clearly attributable to hypothermia. The social security answer to that has been readiness to provide an extra allowance for fuel. However, if one happens to have arthritis and to be very elderly, and to be living in a house heated only by some kind of solid fuel appliance (and it is much too cold to get out of bed in the morning in order to collect the fuel in order to start up the fire and so on), it really does not make sense to have provided to you money to buy fuel. If one cannot collect the fuel, it cannot be used. In some cases it would seem a more common-sense arrangement to provide a service which, after all, could easily include the use of electric storage heaters. Again, a telephone could be provided under personal social services by a local authority for housebound old persons, or it could be paid for by Social Security in the form of a supplementary allowance. Similarly, an extra allowance could be made for food, rather than providing a local meals service or free school meals.

On the whole, in Britain the tendency is to go for providing a meals service for housebound people, wherever possible, through the local authority or by voluntary arrangements. Attendance allowance in some circumstances can be paid from central funds, or the local authority can provide domestic help in the home, and that indeed is the commonest way of providing assistance where needed. Both measures have the intention of avoiding the individual being

taken into institutional care—which, again, would be in a hostel of the local authority or in the hospital if the individual is suffering from a serious handicap.

Various accommodations are possible under the general principle of cash from the Social Security office and service from the local authority. My main concern today will be the relationship between services provided locally by different authorities; but the background of cash payments, insurance-based or other, is of course, necessary. Remembering the French concept of the social budget, it is apparent that cash and services have to be financed from the same pool of national resources. The British decision, made in 1974, to provide the sum of £10 for each Social Security beneficiary as a midwinter bonus, was in fact a decision that about £70 million not be used for the support of some service—because it all came out of the same available funds.

Equally, a decision to spend more on health services or on institutional social welfare services is a decision not to spend that money on other services or on cash benefits. The public may not always realize this, because the public tends to think that the public purse is bottomless, except when it is required to pay taxes into it. The decision may be right, but in a period of financial stringency that is the effect, and if a government chooses to increase Social Security payments and shortly thereafter has to retrench, it never seems to want to take cash payments back from people who are, after all, electors—so it trims its services.

Even at times appearing relatively affluent, one can in fact be mortgaging the future of service when cash allowances are added to. In one of our earlier discussions there was mention of the development (under Poor Law and its successor, Public Assistance) of the system of support services for the indigent, including institutions for the reception of those who were neither mentally ill nor handicapped nor physically sick to the extent of requiring medical supervision or continuous nursing care. Residential care for children deprived of family support was formerly a Poor Law or Public Assistance responsibility, but because of some really very distressing cases reported just after World War II, special children's departments of local authorities were recommended for initiation. The central responsibility, which at that time rested with the Ministry of Health, was transferred to the Home Office (and it was alleged that one leading Minister at the time said that this was necessary in order to humanize the civil servants). Well, that may be a very laudable aim, but one really ought to reflect on the people who need the humanity, who are, in these circumstances, children. Still, a good job was done.

After 1948 there were four separate components of social service under local authorities, and some social work services provided by the hospitals. These isolated activities comprised the care of deprived children under the children's departments; care of old people and other physically handicapped people under welfare services, both in hospitals and in day centers which were the direct inheritance from the old public assistance, training and occupational centers for the mentally handicapped and social support for the mentally ill under the National Health Service Act and later under the Mental Health Act. After-care of the sick originating with after-care for the tuberculous and home help in case of illness was also under the National Health Service Act, and it was pretty much of a jumble.

After nearly 20 years, during which the social work profession had been evolving, it was time for consolidation. The social work profession had not developed as quickly as in the United States, and it was partly a service related to health services in one way or another. Indeed, the organization of social workers was called the Institute of Almoners up until a short time ago. I recall that when its president was a distinguished professor of pediatrics, I was one of the last doctors to be asked to address the Institute's annual meeting.

The report of a committee under Frederick Seebohm, who is now Lord Seebohm, recommended consolidation of all these social work services, of each county and large borough, into one comprehensive social welfare department of the authority. This took place through a series of steps beginning in 1971, and in 1974, when local government was reorganized, the arrangements were shaken up again, and transferred to the new and smaller number of local authorities (just under 100, where previously there had been about 160 of them). But those areas were also the areas, though not the electors, of the new area health authorities, about which I talked on earlier occasions. When the mental welfare services were transferred to the social welfare authorities, the training centers for mentally-handicapped children were transferred instead to the education system. That was an interesting development which grew up under health, because the health authorities appreciated that mentally-handicapped children were still capable of training, and they established training centers which the education authorities were rather aloof about.

These changes in the social welfare system removed from the health system a great deal that it had pioneered. The change had been opposed by the health staff, and was very much resented when it occurred. A number of medical officers of health and their employers had put great effort into development of social welfare; two of them were so deeply involved in the social welfare side of their work, that they actually chose to apply for and secured appointment as directors of social welfare, leaving their medical work behind them. Only one of those is still in office, but two of the original directors of social welfare were doctors. Many public health nurses, too, resented giving some of their responsibilities—or what they had regarded as their responsibilities—to newly-appointed social workers, saying with some reason at that time that many of them had not been properly trained in social work. Some general practitioners strenuously objected to the transfer of responsibility for domestic-help-in-the-home for people who were sick, to a department other than the health department.

There also were particular problems about obtaining the help occasionally needed for admission to hospital of a patient with serious mental disturbance. Under British law, mental health officers were the people to whom the general practitioner applied if he wanted urgent admission of a mentally-disturbed patient to a mental hospital. In the old days of the Poor Law, he would apply to the local officer of Poor Law, who was called the Relieving Officer, because his job was to relieve various kinds of distress. When the changeover first occurred, there were considerable difficulties about getting patients admitted to mental hospitals in cases of urgency, though there might not have been if the mental hospitals had been more ready to respond without the presence of an intervening welfare officer with the right to demand the admission of a patient.

There was a serious shortage of well-trained social workers. Training for new recruits, and retraining and in-service training to broaden the experience of the existing workers, required much expansion of training facilities—just as, since then, it has been necessary to expand rapidly the facilities available for the training of physicians in community medicine. Hospital medical staffs, especially in psychiatry, often complained that they had lost experienced staff who were attracted by the higher remuneration in the new field. Some specialist units undoubtedly gained because they had done nothing about developing social work services of their own, and were now able to share other people's. Others equally certainly lost under the new arrangements.

Despite the disturbance, and although there are still areas of grave shortage of staff, there is not much doubt that the new social welfare departments will be able to develop better services within the new framework than would have been possible under the old. The new pattern is necessary if the social work profession in Britain is to mature and the social work services are to be developed. There had to be detachment from medical control—even if it was benevolent medical control—if the profession was to develop in its own right. The medical evidence given to the Seebohm Committee, which made recommendations to government about social work services, practically all favored consolidation of the social welfare services, but it also declared that this should be within the health department. I think the Committee came to the right conclusion, because that indication of medical possessiveness was probably the clearest indication that the child was due for weaning.

The new arrangements mean that the area health authority is expected to provide whatever medical advice the local authority, which served the same area, may require on the development of its social work services. The social welfare authority is expected to provide social work advice within the health services. These expectations have been laid quite explicitly on both kinds of authority, and though, because of local personalities, there may be obstacles to getting them carried out, there are a good many areas where there already is excellent close liaison, and there is no difficulty at all about the fact that the principal social welfare officer may have been junior to the community physician in an earlier existence.

It can be argued that the powers of the social welfare authority should have been conferred on the area health authority. This has been maintained by, curiously enough, quite a lot of doctors, as a necessary process of further integration. It is quite possible that this could be the next stage in the reorganization of local government, maybe 10 or 15 years hence. Had it happened in 1974, it would greatly have strengthened the arguments for making the area health authority the elected local authority, thus putting everything together under elected local government. That would have been totally unacceptable to the clinicians in the medical profession, and to the dental profession and to a lesser extent, I believe, to the nursing profession. Certainly there would have been hostility in the health professions such as would have caused a great deal of disturbance—if the 1973 Act had made that provision.

Moreover, a separate social welfare department would still have been necessary, and it would then have been necessary to deal with two departments under the one authority. The social welfare department might have had a very hard struggle to secure adequate resources against the pressure for more money for health. It is always easier for the electorate, central or local, to see the large

institution rather than the service, which may in fact cost a great deal more, but also be more valuable. Area health authorities were entirely new authorities and, had the welfare responsibility been transferred to them as well as the health, all the new lessons they have to learn regarding health administration would have been infinitely more complicated by the need to learn the other things at the same time. They were appointed, not elected, and in Britain we have taken quite enough responsibility away from locally elected government as it is. I do not believe it would have been a politically acceptable arrangement for either of the main parties in Parliament at the present time. If anything, social welfare services have greater need for direct contact with the public, through its elected representatives, than has the health service.

These social welfare services are essentially local, with a much smaller and different regional aspect than that possessed by the health service. Other local services, such as housing and education, area planning and probation services, need to relate to the welfare services more closely than to the health service. There have to be arrangements for liaison between area health authorities and the elected local authorities and they are required to appoint joint liaison committees. And they are required to arrange for mutual use of officers, a requirement that is not included in the law because there is a custom that you do not say you *must* do this to an elected local authority. The end is secured by other means, including the arrangements made for grants from the center to the locally-elected authorities.

Often, right at the periphery, it is now possible to locate staff together. For instance, England's largest health center, which is in one of the northern boroughs, Teeside, has in it 24 or 25 general practitioners. There is an office covering the same district of the social welfare department on the same floor and providing its services in close collaboration with the general practitioners. Naturally, the main cooperation between these services is at the district level, not at area or regional levels, and it takes place between professional staffs. For instance, the geriatric department in a hospital is going to need very close relationships and often exchange of patients or residents, with the hostels for the aged and infirm run by the local authority as part of personal social services. There are about twice as many places for old people in those hostels as there are in geriatric wards. Home support for someone who has been in hospital is partly public health nursing, and partly social welfare support. Home help, which is now used by something like 486,000 households in the course of a year, is provided by the personal social services department. Meals-on-wheels, mentioned earlier, are provided now to the tune of something like 30 million main meals a year. They also link with home nursing and with general practice. In mental health there is direct social work participation in psychiatric work in hospitals on an increasing scale. Indeed, at present, there is not enough social work staff to provide all that is needed. Some patients on leaving a psychiatric ward may need to go into a hostel for lack of an appropriate home. The arrangements for urgent admissions for social reasons, for the safety of the patient, have to be made through the social welfare department. The general practitioner has to be in touch with all these groups as well as with the hospital.

In child psychiatry the social work support of the child psychiatric department has to be provided by the social workers of the local authority. Under the School Health Service they must also work with the educational

psychologists, and here again, the general practitioner is involved. There is a common link with the educational services, and again, there are some hostels used for children with particularly severe maladjustment. In such problems as child abuse there must be exchange of information with the hospital and with the general practitioner. There must be home visiting, usually by a social worker, or sometimes by a public health nurse. It may be necessary to take the child into the care of the local authority, either into a nursery or into a foster home, and on the hospital side there are not only the pediatrician, but also the accident and emergency department.

We have had a problem—as I know you have in the United States also—which calls for a degree of cooperation across the board between health, education and social welfare services. In Britain, we are beginning to achieve that cooperation, I hope, but some very unpleasant tragedies are still reported from time to time. Having been reading the *New York Times* assiduously over the last couple of days, I have learned a good deal about the problem of wife battering, which is an occupation followed by, I fear, some men in both our countries. That involves not only hospital authorities, but perhaps more social workers, and to some extent general practitioners and, of course, from time to time, the police. Again, this requires a person-to-person kind of cooperation. Maternity care involves provision for confinements usually in hospitals in both our countries, but it may also involve the provision of domestic help in the home, which can be done by the social welfare authority. Also involved are the hospital, the general practitioner and often the midwife in the community and, of course, if the baby is born out of wedlock, there may be the problem of adoption and of social support of the unmarried mother. Generally, in child health there are the problems of adoption and fostering, of nurseries, residential or otherwise, for children who have lost their parents. The pediatrician, the obstetrician, the general practitioner, the public health nurse, and the school health service again are involved with each other.

There is an increasing number of places in hostels for the mentally handicapped, and occupational centers for adults run by the social welfare authority. There also are training centers for children run by the education authority. The general practitioner and the relevant psychiatrist, the school health service, and home support by home help or otherwise—all are concerned in care of the mentally or physically handicapped.

In hospital work generally there is a problem of home support for some cases. In the course of a year, the commonest reason for the social welfare authority taking a child into care is short-term care necessary because of the illness of one or both parents.

The key people in this coordination are the area medical officer of the area health authority, and the director of social work. If it is a multi-district area there are community physicians in each district. Whether or not these services are going to collaborate as they should in the last resort depends on the effective professional relationships existing between those people, much more than on the common interest of the two different, or three different authorities (if one includes the educational authority which tends to have a certain amount of independence within the work of the local authority in general).

That is the set-up which attempts to secure a partnership of these different services. I have not tried to give you details about the numbers involved by

different classes, although this information is available. (In particular, there are various groups of physically handicapped, blind persons and so on.) At the last resort, it comes down to sensible joint working at the district level. Most health services, and most district welfare services, depend absolutely on the sensible functioning of individuals at district level, much more than on anything that may be put into Acts of Parliament.

DR. THOMAS D. DUBLIN: Sir George, you have described the services rendered by the social welfare arm and the health arm in terms of dealing with the diagnosis and treatment and perhaps continued care of the handicapped or the sick. It seems to me that we have learned from the British experience, particularly in the United States, of the inseparable bond that exists between social class and morbidity and also mortality. In terms of attempting to order the demand for services or the need for services, whether they be health or social welfare services, has there been any effort in Britain to attempt to demonstrate the cost benefit of some of these integrated services that you have alluded to, and perhaps the benefit that might accrue in terms of diminished costs for health services by alteration of social status, or way of life of the population groups?

SIR GEORGE GODBER: Certainly, I think there have been attempts to do that, but I do not know of really convincing material about it. Sir Keith Joseph, when he was Britain's Secretary of State, talked considerably about the cycle of deprivation. He pointed out something that we all know, that people who are deprived, who come from unsatisfactory homes, are more likely themselves to generate unsatisfactory homes and unsatisfactory conditions for their children than those who come from better homes. Whenever that is enunciated, I always think it is a blinding glimpse of the obvious; but it is true, and it is true that we do not do enough about it. In Britain there were some special service units, which first appeared during World War II, provided by Quakers who worked with what were called the "worst problem families" in order to try and ameliorate their conditions. But if we are hoping to get the most satisfactory result, we really ought to start much earlier than that. We ought to be trying (and I was thinking that you were going to castigate me for not saying this) to prevent the emergence of some of these problems. We should recognize the factors making them more likely to emerge. One deprived child coming from an unsatisfactory home is more likely in later life to reproduce the same situation with his or her children. Just how one could obviate this, other than by very general social measures, I do not know.

In a book produced by the National Institute of Child Welfare, called *From Birth to Seven*, there is a very clear description of the way in which certain services are used more than the average by certain social groups, and a mention that the preventive services which might be most useful to them are the least used by them. I think one is simply enunciating social truisms that we all know, such as: "Bring a child up in bad circumstances, and he is more likely to provide bad circumstances for posterity." So I haven't answered your question at all. Can you?

DR. DUBLIN: In the hope of encouraging the concept of a colloquium, Dr. McCrumb of the Fogarty Center in the last year or more has been attempting to bring together the best thoughts and wisdom of the American College of Preventive Medicine, in part prompted by the fact that the Assistant Secretary's Forward Plan for Health emphasizes the importance and the desirability of placing a greater emphasis on prevention in the health care services. Obviously, the implications of what you have said and others have said is that many of the consequences of social maladjustment, of social disorder, are borne out in terms of morbidity and mortality in the health area. So in terms of prevention, we have to use social instruments as much as we do diagnostic and medical instruments, in terms of need. Perhaps if I am probing a little bit, it is because I am still at a loss to quite understand what the functions of the newer community physician are going to be (as described in John Brotherston's monograph), or in some of the developing programs south of the Scottish border, in terms of the community physician. How will he be trained and how will he function in terms of the integration of these health and social parameters?

SIR GEORGE GODBER: At the present time the community physicians are mainly the lineal descendants of the Medical Officers of Health. They probably had more to do with this kind of problem as medical officers of local authorities in the past than did anybody else, except the children's officers. They were accustomed, usually, to working closely with the children's officers, and now they are working closely with the directors of social welfare. They have plenty of opportunities to make assessments of the situation in their area. Their job, after all, is to make informed assessments of the health situation in their areas, and the factors which contribute to the worse elements in it, and to bring these to the collective attention of their clinical colleagues, not only in medicine but in nursing also. There are nursing officers for the same districts working alongside them.

It all sounds delightfully vague, I know. It is a bit like saying you will recognize it when you see it. I think that is largely true. We know there are lots of parameters for measuring ill health, particularly among children. Some of the best pioneer studies in this area have been done in Newcastle, England, as a joint exercise by the Department of Child Health of the University and what was the Maternity and Child Welfare Department and the School Health Service of the Authority. My predecessor, Sir John Charles, and Sir James Spence were the originators of the Newcastle studies. These began just after World War II, in 1946, and continued until 1,000 children who were the subjects had reached adult life. There has been a series of publications of that kind. Single-parent families provide the examples best demonstrating the handicaps.

The infant death rate of illegitimate children is approximately 60 percent greater than for those born in wedlock. If it is remembered that of the children born out of wedlock, about one-half are born to stable unions, and have the same infant mortality rates as the others, it will be seen that the problem is concentrated in a smaller group of unsupported women, who often are young. In Britain we had a committee which considered single-parent families and made recommendations about particular kinds of social help, including

additional financial help being given to that kind of family. This is just one area in which something more positive can be done.

I do not believe that the community physician can do more than call attention to the situation's health components, for which he can get a contribution from the health services. Educational and social welfare components may be a good deal more important. It is my view that when we start talking about this we emit clouds of cotton wool, saying. "If only things were better, everybody would be better for it." And at the end of the day that is perhaps all we have said. But there are individual things that can be done about health. There are things that can be done wrong by following the principles enunciated by some of the experts. We have had too many occasions when a child has been killed or seriously injured as a result of people's determination to keep families together—because a child is abused before the authorities can quickly arrive to remove that child. Some unfortunate social worker, or nurse or doctor, usually gets the whole of the discredit for that, when really we all should be sharing in it, those who have been neighbors and had anything to do with the case at all. Sometimes, too, the courts can be absolutely ludicrous in insisting that because a child was born to a particular mother, that even though that child has lived for many years with a foster parent to whom the child is devoted, the mother can claim him or her back. We have had that sort of thing, and it is a very disputatious area. I do not believe that there is a single answer to it.

UNIDENTIFIED SPEAKER: You stressed the need for common sense cooperation between professionals. Do you feel that it is harder to get it cross-profession, or within the profession, or has that issue been faced in Britain?

SIR GEORGE GODBER: I think most professions are a particular kind of human arthropod. They surround themselves with a rigid exoskeleton, which is the custom of our profession, and it is a very painful process to molt and put on a slightly different-shaped skeleton. Yet we do it in scientific matters, because we get continuous patterns of change, and it all looks very worthy and orthodox. When it comes to conceding something to a group from a different discipline, we tend to fight for the supposed rights and responsibilities of our own profession. It is difficult, therefore, in a rather special way, to get one profession to accept freely the benefits which working with another can give. We display it most clearly in the authoritarian approach of doctors to nurses. After all, they are in the same family, and we often fail to realize the distinctive contribution that the nurse can make in health care. One can see extreme possessiveness within specialties in medicine. For example, the general surgeon who likes children and is therefore prepared to do children's surgery, even though a colleague would do it better because he is a pediatric surgeon.

I do not believe things are as difficult within the profession as they are between professions, and I cannot see why all of us in the profession should not concede more readily to the others. That is a fine general answer for you, but it does not give you any specific help, I am afraid.

UNIDENTIFIED SPEAKER: I think it is one of the most serious social problems we have, in working as a whole organization.

SIR GEORGE GODBER: Yes, I am sure this is true, but one need not despair, because I have seen it happen in general practice in Britain—the association of medicine with nursing, on a really free basis of choice. For example, this was never directed from the center, although a good deal of encouragement was given. Where individuals in the professions are ready to make suitable concessions to each other, I do not know of any interprofessional collaboration that is more successful, even the doctor-nurse collaboration within hospitals. I believe it can be seen at its best in general practice because there are fewer white coats and less attitudinizing.

But this collaboration and conceding does happen and, provided no one attempts to enforce it by law, or tries to make rules about it, I think one can get continuous change in this way. I am not as despondent as you sound.

MS. KATHRYN ARNOW: What opportunity is there for the patient or the consumer to voice satisfaction or dissatisfaction or to help moderate or modulate the many relationships you have been talking about?

SIR GEORGE GODBER: There is the opportunity that occurs at ground level when the patient might resent, perhaps, being asked to make his or her first contact with a nurse in a group practice, as was earlier mentioned. If complaints are to be voiced—apart from voicing them direct to the individual professionals with whom one deals—there is the fact that social welfare services are provided by locally elected authorities and the aggrieved individual can always get at the authority through his or her local representative. After all, the member for the particular ward or village of the authority is there to respond to feeling in his or her constituency, and he or she had better respond, or not be elected next time. There is always that situation on the elected side, and also the device of the community health council, established on the health side, which gives an opportunity for people who represent the public locally to make their views known to the health authority.

So, failing the kind of personal adjustment that can be achieved by direct contact with the individual in the profession, there are these other channels (apart from complaint regarding a defect, or a failure to provide services) which can be used by the individual member of the public. Of course, at the end of the line there is the formal complaint to the authority, or perhaps to the health service Ombudsman. I will be coming to him in a later discussion. In health service and in social welfare there are strong inhibitions relative to the individual finding fault with the service giver. At the back of this may be the thought that: if I find fault with this one and continue in my relationship with him or her, I am not going to do so well in that relationship as I might have done if I had not complained.

MS. ARNOW: In addition, I was thinking of the just natural awe that patients have of physicians, quite apart from whether the patient expects that the physician or the nurse will be peeved with and dislike him, which I doubt would happen with most professionals. There is simply a tremendous all-over reluctance to question and answer physicians.

SIR GEORGE GODBER: You said natural awe. Is it natural or unnatural?

MS. ARNOW: We had a speaker in an earlier conference sponsored by the Fogarty International Center, Victor Fuchs, who has worked on the economics of care. He thinks it is perhaps a bit of a theological, a religious awe. A priestlike relationship.

SIR GEORGE GODBER: Yes, because you really hope that the doctor can do magic for you, don't you?

MS. ARNOW: That is what he said.

SIR GEORGE GODBER: When you are ill, I think that it rubs off onto the doctor, who after a while begins to think he can. (Laughter) But, look, these are human obstacles to rational behavior, and I am quite sure they cannot be overcome by committees of investigation and that sort of thing. We have had a surfeit of those.

DR. WILLIAM HOLLINSHEAD: At this kind of ground level of the service professions, it seems to me that in part because of this religious awe, the consumer is tending to sort of vote with his feet and to seek other services if he is dissatisfied; and perhaps that is the best solution for the problem. But my question is: When you reorganized services in a major way, put different labels on the doors and different people in charge of old services, was there any planning—at least on the local and district level—to teach the patients the new pathways, the ways in which they might find their own way to the advice and the help they felt they needed under the new system, or would that simply occur as an organic process with the patients doing it for themselves?

SIR GEORGE GODBER: So far as the health services are concerned, one has the traditional access to the family doctor, so I do not think there is a difficulty; I believe everyone knows that as a source of help. The actual definitive help may not come from that source, but that source is responsible for getting you to it. The doctor will not say, "Sorry, chum, it is not for me." He will say, perhaps, "I believe you will need help from the social welfare department; I will refer you to it," or he may say, "You should have been in hospital; I will arrange it." On the health side there is that traditional point of contact, and it is true that the individual dissatisfied with his point of contact can vote with his feet, as you said. He can change to another doctor. The fact that it is not done very often may partly reflect the fact that it is an uncomfortable thing to have to do, because you have to go to your doctor and say, "Look, I want to end our relationship." But I believe it does largely represent a sort of continuing loyalty between patient and doctor; the feeling that there is an established relationship preferred to some different relationship with persons unknown.

On the social welfare side, there was again a tradition of access to some kind of officer, and there are local offices where one would expect to see the individual who would be able to help. On the Social Security side, when there are questions of particular allowances, one visits the Social Security office, asks the questions and receives answers. And there are all sorts of explanatory leaflets about entitlements. I do not believe people make full use of these services, although on cash allowances and that sort of thing there has been a determined

attempt to educate the people by leaflets, by publicity, by public discussion. Many still go short of services they might obtain.

There is no longer the old stigma of the Poor Law, of the feeling that it was slightly discreditable to go seeking service. On the personal social services side it is believed that the offices are sufficiently local, and that the officers are beginning to be sufficiently well known, for such inhibitions to be at least declining. But I am not saying the difficulties are not there.

CONSUMER INTERESTS, EXPRESSED THROUGH THE COMMUNITY HEALTH COUNCILS, THE HEALTH SERVICES COMMISSION AND OTHER INSTITUTIONS

DR. MILO D. LEAVITT. Our subject today is the manner in which the British Government deals with consumer problems in the National Health Service. In view of our own interest in this problem I am sure that Sir George's comments this afternoon will be especially appropriate.

SIR GEORGE GODBER: Thank you, Dave. The Health Service, of course, must be a public concern. Sometimes there are feelings in the professions that they are the best judges of what should be done to and for patients, who should accept that judgment. Perhaps that was encouraged in former times by the charitable origin of many British acute general hospitals and the absence of any fee-paying relationship between the patients and the doctors concerned. All British hospitals either had salaried medical staff or the staff were honorary. In the famous teaching hospitals in London, for instance, or the voluntary hospitals generally, the staffs were honorary.

When the Health Service was introduced it was obvious that, since the public was paying through taxes and since the public was being served and intimately and personally involved in what was going on, it must be their concern. The original hospital boards—which had appointed membership—had members who were supposed to act as individuals, not as delegates representing any particular interest, not more than one-fourth of them were medical. There might be a nurse; there might be a dentist; one of the physicians might be a health officer. They included a number of elected members of local authorities who were chosen by the Minister, not nominated by the authority. There was usually at least one trades union member. The rest were people who had exhibited an interest in the running of health services, and they were rarely political appointments. That situation was not invariable, but by and large it was how things ran.

The regional boards appointed management committees on much the same basis. In the boards of governors of teaching hospitals, three-fifths were nominated by regional hospital boards or by the medical staff or by the university; they tended to have a larger proportion who were medically qualified. They really had no constituency, any of these appointed bodies—they had no electorate to which they were answerable. They were criticized by one distinguished politican, now dead, as "self-perpetuating oligarchies." As a matter of fact they did rather well, but they lacked public contact and they lacked appeal to the public as groups, even though many of them would be known individually. However, they—particularly the management committees—had reasonable contact with the sector of the public they were trying to serve. I always remember the chairman of one of the London teaching hospital's board of governors who was in fact a Labour peer—when he got the names of his list of governors he could not identify one of them until the first meeting, when he

discovered that the man in question was the person who went around the hospital wards selling newspapers. He was quite disturbed about that—but should he have been?

The councils that managed the family practitioner services were nominated. They were one-half professional, one-third nominated by the elected local authorities and the remainder selected by the Minister. They were almost unknown and they operated complaints machinery in the general practitioner services anonymously. There were sometimes complaints that no one knew what went on and that because of this, if justice was done it was not *seen* to be done. On the other hand, the local health authorities who ran the personal preventive services and the support services were elected for counties or cities and they did have public health committees answerable to them. Health was not a major interest of the elected authorities in Britain as it was in Sweden, or in New Zealand for that matter, but there were members who could be approached by the electorate if anybody was dissatisfied with the way services were provided.

The 1974 changes modified this to the extent that today Britain has regional health authorities and area health authorities that are smaller than the authorities that went before—smaller even than the hospital authorities. The regional members are appointed by the Secretary of State. He also appoints the chairman of the area authority, but the members of that body are appointed by the regional health authorities. The members are appointed partly from elected members of the local authorities and partly from people put forward by the professions. These bodies are small, they are meant to be managing bodies; they are less obviously in contact with the public they are supposed to be serving than the bodies that preceded them for hospital or preventive services. The area health authorities also are required to have family practice committees, which are nominated on the same lines as the preceding executive councils.

The real kernel of the Health Service is the district—the district that needs a district general hospital to round off the services and that contains a number of group practices or health centers or individual practices or pharmacies giving primary care. At the district level there is no committee machinery at all, and this is one of the weaknesses of the revised setup. The districts are run by management teams comprised of officers appointed by the area health authority. Now that is reasonably close to the public if the area health authority only has one district, but most of them have more and one of them has as many as five.

The present British government has been concerned about this, which it regards as an undemocratic arrangement, and it has decided to increase the size of these area health authorities, nominating two additional local authority members to the area health authority. These are people who have been elected to the local authority for other purposes, and therefore they have a constituency to which they relate.

The reasons for non-election, for not choosing to have an elected body for running the Health Service, are: first of all, the rooted objection by the professions, especially the medical profession. The nurses might not have minded so much because many of them were accustomed to being employed by local authorities. But the doctors, and to a lesser extent the dentists, were determined not to be employed by a body which might then discuss their

professional activities in open meeting and feel that it had the right even to intervene. However, there are more practical reasons than these reactions of the professions. It is important to avoid any restrictive effect from local authority boundaries. Local authority boundaries, although they have been revised, are still not boundaries that one would generally have chosen for running health services.

In England there is a regional level, also with an appointed authority, but in Scotland and Wales there is not. There is no regional level in local government, which is another reason why it would not have been advisable to turn over management of health work to elected local authorities, even if the professions had been willing, unless there had also been a radical reform of local government in this respect.

Additionally, there is a very large financial responsibility, resting mainly on central taxation. The Treasury does not like to feel that it is handing out 5 percent of the GNP to meet the cost of services that at present run at nearly $7-1/2 billion a year to local authorities, that could spend the money but did not have to collect it. Local authorities' revenues come from property taxes and there is, for instance, no local income tax or local sales tax such as some other countries have. In Sweden, where they do have elected local authorities, more than 85 percent of the expenditure of the authorities is on the health services, as well as the central contribution. Then, too, the local authorities were lacking in experience of the two main components in clinical service—hospital and primary care—which account for 95 percent of expenditure on the Health Service. Elected local authorities are less amenable to national influence, whether it is on the method of providing care or on spending, than appointed authorities who either do in general terms what the Minister asks or find themselves no longer appointed at the next change.

In the early days some action had been taken to compensate for the fact that many hospital authorities were appointed, and thus were not answerable to a constituency. Of course, members would nonetheless be local people, and would visit, even inspect, the facilities. Most hospitals also had their own leagues of friends—voluntary groups collecting money by various means, taking interest in what was happening in the hospitals, and helping to finance amenities for patients and sometimes for staffs. Quite often, people interested in this way would leave legacies to the hospitals. It was a quite important method of keeping contact with the public to be served. Also, the British Red Cross Society and the Royal Women's Voluntary Services and similar bodies took an interest in the hospitals and provided voluntary service in them. Especially, some of these bodies' junior members would give voluntary service in the care of patients. Among the professionals, the establishment of postgraduate institutes meant that all professionals working in an area, whether working in the hospital or not, had a focal point linking them with the hospital and with each other. There were all sorts of devices, such as "open days" when the public would visit the hospitals, and public annual meetings when people would come and talk about the work of the hospitals. These related almost entirely to the hospital component of the service.

Meetings of regional hospital boards and of management committees, like the meetings of the regional health authorities and area health authorities now, were open to the press. Committee meetings were usually not open, but very often committee papers would be available to press representatives. Members

of the authorities would visit the hospitals regularly—all of the hospitals in their groups. Sometimes individual members of a hospital management committee would be assigned to make contact with one hospital in the group. House committees for individual hospitals tried to bring in additional voluntary contact but they were not very successful. Many tried to interfere in management responsibilities which should not have been theirs. But the management tried to familiarize patients with the organization of the hospital and their rights in regard to treatment, including affording guidance on how to make complaints if they so wished, giving them an opportunity to make a note, at the end of their stay, of comment on the service they had received.

There is, of course, a tendency for all recovered patients to be extremely grateful, to be glad to be going home, and to be quite uncritical of the people who were attending them in hospital. But even allowing for that, I think that committees, such as the one of which my wife was a member, really did have the opportunity of hearing from patients about things that they found wrong, or things that they found advantageous in the hospital in which they had been treated.

The complaints machinery for the Health Service was different in different sectors. In the family practitioner services, medicine, dentistry, pharmacy and optometry, there were service committees for each branch. Anyone feeling aggrieved was required to make a complaint to the executive council. The chairman of the executive council (who usually was not medically qualified, although sometimes one of the professionals would be chairman) and the council itself, consisting of balanced professional and lay members, would consider the complaint. Either the chairman or the clerk, or both, might take informal action in something that seemed trivial, to perhaps mollify the patient or prevent a grievance from going any further. Perhaps, simply, a friendly word to the doctor or dentist or pharmacist about whose conduct there had been a complaint might prevent anything of that kind from re-occurring. However, if the complaint was serious (suppose someone complained that his old mother had died without having received medical care because the doctor, although summoned, had not attended, or he had attended and been quite careless in his activities) the doctor might be held not to have complied with his terms of service. The council, on the advice of the service committee considering the case, might recommend a withholding from his remuneration. There would be a right of appeal against that decision, whether it went for or against the doctor or dentist, or whatever, to the Secretary of State. Such appeals were usually sent to a formal hearing, or they could be referred to an advisory committee consisting partly of doctors in the health department and partly of representatives of the profession from outside the department. Quite severe penalties could be imposed. I recall the withholding of £1,500 from a doctor whose total remuneration from the National Health Service was of the order of only £3,000. That particular offense, oddly enough, was for prescribing tetracycline for the local treatment of varicose ulcers; the doctor had a firm belief that it was advantageous. But for some considerable time he had been costing the Health Service more than £30,000 a year in carrying out this treatment, and he could be dissuaded only by having such a penalty imposed on him; a penalty that, had it continued to be imposed, would have precluded his continuing in the Service.

Mostly the penalties would comprise the withholding of smaller sums, but an extreme case could involve reference to a special tribunal which might recommend removal of the practitioner's name from the list in whichever discipline he was practicing. If the conduct of a doctor had been particularly disgraceful the whole of the proceedings might be referred to the General Medical Council and the person concerned could find himself taken off the medical register and no longer able to practice. There were not many cases of that kind, but there were a few. Broadly that system continues.

Complaints made to the local authority would be handled by the members of the authority; there was no special system of inquiry prior to the recent changes. Complaints to a hospital management committee or to a regional hospital board in the hospital services might be handled locally by an internal inquiry and an explanation. But they were always recorded and acted upon immediately; and they would be disposed of in that way unless they were so serious as to warrant a more formal kind of inquiry. The complaints book was available for management committee members to see; it was often thought that hospital staff tended to close ranks and to dismiss complaints if they possibly could. In the early stages that may have been partly true, but I believe that as time went by the handling of complaints was taken much more seriously. Ministers certainly took them seriously. After the report of a special committee some 3 years ago, the action was made generally similar, involving reference if necessary to a special committee of inquiry.

A formal inquiry with a legal chairman in a serious case—as for instance the doctor who twice failed to undertake cross-matching of blood given to a patient who subsequently died, even though the facilities were available to him—a formal inquiry on that which led to the doctor's dismissal, is an example of the extreme case. There weren't many like that. Today, all complaints go to area health authorities or to regional health authorities, and the local system proceeds much on the lines of that previously adopted in the hospital service.

Sometimes people complain by writing letters to their Member of Parliament. He will usually go to the area health authority or the regional health authority and get advice as to whether the complaint has substance. If he thinks it so serious that it ought to be pursued with the Minister, he will go to the Secretary of State. Then the Secretary of State goes back down the line to inquire from the area health authority or regional health authority concerned. The Secretary of State will not entertain a complaint about a general practitioner because he is the court of appeal in the event of a decision going against the practitioner. He will simply refer it back to the formal machinery of the family practices committee. He can if he chooses, on a sufficiently serious matter, set up a formal inquiry of his own, with a legal chairman and professional and perhaps nonprofessional assessors. Recently, quite a number of inquiries of that kind have taken place regarding the provision of longterm care, particularly where there have been allegations of serious misbehavior in custodial type hospitals—for instance, those containing the mentally handicapped. After all, when there are more than 200,000 mentally ill or handicapped or chronic sick patients in the hospitals at any one time, it is going to be surprising if there is not anywhere among the attendants the sort of person who simply should not be there, and who will maltreat a helpless patient. We have had perhaps more than our share of complaints of that kind.

There are also problems arising from professional failure, and these can be extremely difficult. The example of the anesthetist who sniffs the anesthetic gases and who may render himself unfit to continue with his duty is an extreme case--this happens, and as we all know, not so very uncommonly. A man anesthetizing patients for a registrar-surgeon had two patients die who should not have died. He was held responsible by a coroner's inquest and was dismissed, and in fact his name was later removed from the medical register. He was an addict to the anesthetic to which his job exposed him.

In order to try to forestall that sort of thing, a system was set up in every hospital whereby what were called "three wise men" would be designated: three senior members of the medical staff, to whom any member of the staff feeling doubtful about the capacity of another member of the medical staff would go. I do not believe the system has worked very well. It has been used effectively on some occasions, but it is a very difficult situation to have young doctors complaining about their seniors. It could well be a surgical registrar or a resident feeling that his 60-year-old chief is losing both physical and mental capacities to discharge his functions, and the complainant does not like to go to another senior colleague and complain. In theory it ought to work; in practice it has worked sometimes; but it has not been as effective as one would like to see it made. There has been an attempt to improve that recently.

Mr. Richard Crossman, when he was Secretary of State, set up an independent organization known as the Hospital Advisory Service, which was not a section of the department. Although I was Chief Medical Officer at the time and the first director was formally a member of my staff, he was not answerable to me for his work in this capacity. The director reported directly to the Secretary of State, and his reports were considered by the health authorities and by the staff of the department. The team spent their time looking at longterm care, starting with mental handicap, about which we had the most concern, and moving on to mental illness and geriatrics.

Teams consisting of, usually, a doctor, a nurse, an administrator and perhaps one other, would visit each of the hospitals providing this sort of care in turn and write detailed reports on their findings after a stay of up to a week. Those findings were often extremely valuable in bringing about improvements in individual hospitals. They led to the publication of annual reports of the Service, and those annual reports called attention to a lot of things that needed remedying. They also helped obtain extra funds for the improvement of long-term care.

Personally, I have some doubts about this method, because it involves people descending on a hospital, making a report, and going away; and they are then no longer involved in the responsibility of trying to remedy what they have seen. I believe that something rather closer, such as some regions have adopted, to a peripatetic regional group which will go around, say, the mental illness hospitals of the region; may be more successful. The group need not always be the same, but perhaps could exchange a psychiatrist from one establishment when they move on to the next, shedding the psychiatrist they were using before because he happens to be the person in charge of the next establishment. Such a team has been shown in some of the regions to retain a sense of responsibility and support for the staff, who perhaps are working under extreme difficulties in the hospitals visited.

The two new things introduced in 1974 were the Ombudsman and the community health councils. Since there are no elected committees at district level, the health service institutions do need an opportunity for contact with the public at that level. Community health councils have been appointed for each of these districts. They are appointed by the regional health authority, one-half on the nomination of the elected council of the district—elected for other local government purposes, but these are people with a constituency to which they are answerable—two-thirds of the rest from other bodies interested in the health field, such as the Red Cross and the Royal Women's Voluntary Services, and a sprinkling of other people without specific affiliation but known to be interested in health care. They elect their own chairman, they appoint their own staff; they are financed from the Health Service; their membership is not professional. Although it has been rather difficult for them to get officers of the quality that they need, they do have some appointed (perhaps former employees of health authorities with a reasonable level of experience) and some at least have begun to show an intelligent and helpful interest in the way that the Health Service works in their district.

A few of the community health councils may behave as if they believe they are there to harass the people providing or managing health care. At this stage that is a risk one has to run. But if only the health authorities and the district management teams will try to cooperate with these bodies, I believe they may find them to be a great deal more help than nuisance. They have a nuisance value and perhaps it is just as well that they should, because there is no reason why everyone in the health services should be exempt from nuisances. But I hope that they are going to settle down and be made to work, otherwise there is a real risk that the Health Service may be looked upon as the government's service and detached from the public it is supposed to be serving.

Members of these councils will visit or at least have the opportunity of visiting health facilities. They have the right to be informed of and give their views on the area health authorities' plans. They may show a tendency to inquire where they are not really qualified to make inquiries but in that they can be advised. They are considering forming a national association so that they may develop a sort of corpus of understanding among themselves about how best they can be employed. The King Edward's Fund, which is a voluntary health service supporting-fund based in London, has been helping this central organization. They have appointed as their chairman, Lady Marre, who happens to be the wife of the Ombudsman. She has had sociological training and has been concerned with health and social welfare service administration. It was for that reason (not because she was the wife of the Ombudsman) that she was chosen by this body to be its chairman. The provisional national association has started to publish a bulletin, the first one or two numbers of which may have seemed a little naive. However, I believe they can be made into a valuable means of contact between the services and the public being served. They can also help people who want to make serious complaints and don't know how, or perhaps are even afraid to do so.

It has been alleged that these councils have a predominantly middle-class orientation. I remember one odd complaint that the chairman of one of them was an admiral. But really, the admiral might well have been the most suitable person in that particular council. The councils' real functions are in contact with the public and as interpreters.

The Ombudsman is appointed by Parliament, under a specific section of the National Health Service Reorganization Act. He reports to Parliament and he makes an annual report which is published. Complaints are made to him directly only if the normal routes have already been used and have not given satisfaction to the complainant. Such complaints are made by those feeling that he or she has suffered injustice or hardship as a result of failure of a service, failure to provide a service, or maladministration of one of the Health Service bodies—not of the central Department of Health—even including the Public Health Laboratory Service which is run independently by a board appointed by the Secretary of State. The Ombudsman can act if a person is not himself able to complain and an officer of the health authority instead submits the complaint on the patient's behalf. This has happened, it is not as fanciful as it may seem. If someone is mentally incompetent to make a coherent complaint, but nonetheless has a complaint which he ought to be allowed to submit, then it is the health authority's job to help him to formulate and submit that complaint. The time limit for hearing complaints is 1 year, but the Ombudsman can, if he chooses, waive that limitation if he believes there is good reason to. He cannot investigate if a tribunal or a court has already done so. Normally he would not if the court could have been used. If, for instance, a patient was aggrieved by what he regarded as a professional failure of the consultant or other doctor who had treated him, he has a remedy at the hands of the courts and he should use that. But if he is complaining about something else, perhaps the behavior of that doctor, which would not have been subject to penalty by the courts, then he can make his complaint to the Ombudsman—if he believes that the health authority has disregarded or not acted satisfactorily on a complaint made directly to them. The Ombudsman cannot investigate clinical action solely in the exercise of clinical judgment. He cannot, for instance, take to task a competent doctor who has decided to do something or not to do something on the grounds that it was not the right decision to make. There is a remedy in the courts if a patient feels aggrieved about that, but the Ombudsman has not the kind of experience or available advice to deal with a clinical failure of that kind.

He cannot investigate the family practitioner services because there is statutory machinery for dealing with such complaints, and there is appeals machinery reaching up to the Secretary of State. But the Ombudsman can deal with a question of maladministration or failure to act by the family practices committee. The investigation is private, the Ombudsman has right of access to documents of any health authority. A report of his conclusions is sent to the complainant and to the person or authority complained about. If it is necessary to bring in someone to give evidence, the expenses of that witness may be paid by the Ombudsman from funds voted for the purpose by Parliament.

In the first year, the Ombudsman handled some 500 cases. About one-half were invalid in the sense that they should not have been made to him anyway. But of the remainder, an appreciable proportion were found worthy of investigation and of some degree of censure. One that occurs to me particularly is that of a consultant censured because the patient had complained about something done by the consultant or not done by him to the health authority. The authority sought the consultant's opinion about this, and the consultant then told the patient that he did not feel able to continue with his treatment, his argument being that there could be no professional confidence between

them after the complaint had been made, although the patient wished to go on being treated by that doctor. In the view of the Ombudsman it was an unwise response, and I think it would have been in the view of many other people. The consultant was censured for taking that sort of line, but the department itself was censured for failing to deal with certain defects in motorized invalid carriages sufficiently in response to a considerable volume of complaint. No one escapes if the Ombudsman gets good evidence of failure by action or by inaction.

That is the way that the admitted difficulties of running a health service through appointed authorities are being handled in the British Health Service today. The situation is a fluid one, and I believe the Ombudsman has thus far had insufficient time to develop his machinery on lines that will be entirely satisfactory to him. The health authorities perhaps have some way to go toward realizing the importance of carrying their public with them, despite the fact that they have no electoral base. But I am quite certain that the handling of these relationships is a great deal better than it was 20 years ago or even 10 years ago.

I do not know whether that explanation is the kind of thing you were hoping to have, but it is about as far as I can go. I shall probably deflect all questions to my wife, because she has operated in it.

DR. LOIS K. COHEN: You described very well a system for consumers, primarily, to make complaints as they react to the National Health Service. Does the Service provide any structure for the consumer to get involved in an active way in the planning stage, rather than solely in a reactive way?

SIR GEORGE GODBER. The question is whether the consumer is enabled to take part in the planning process. Yes, one of the things that the community health council is entitled to is sight of the plans for development of the services. They have the right, indeed the duty, to comment to the health authority. This may be quite widely publicized so that the individual member of the public also can, if he or she chooses, make a protest or support the health authority. One of the recent complaints that I saw was that of people in a particular area who were concerned that their doctors in the area's group practice shut up shop at night and left the responsibility of answering emergency calls to doctors from a relief service in a town seven or eight miles away. The complaint was taken up by the community health council and referred to the authority responsible for overseeing such arrangements. Alterations are being produced in that way.

But in the earlier formative stages of planning, I think the opportunity comes only if and when the health authority takes steps to make its plans known. If it wants to close down a small hospital it will not be allowed to do it unless there has been a serious attempt at public consultation. The community health councils will probably be used increasingly in that. There are opportunities but they are not easy to use. For one thing, health planning is not an art very well understood by members of the general public.

DR. STUART SCHWEITZER: It looks as if you have developed a mechanism for redressing grievances which is wholly apart from the court system. These are problems to which, I gather, we have no remedy at all in the

United States–short of somebody finding a direct legal liability and dragging things out through the legal system. I am intrigued in the sense that you have created a system for resolving problems that we haven't realized we have in this country.

SIR GEORGE GODBER. This may be true but you see we have a system and we ought to have methods of trying to correct that system. If you have not a system, you don't need methods of correcting it. That is perhaps too sharp a contrast, but in the United States you are not caught in the mechanisms of the system. Everything in the health field is within the mechanism of the system in Britain, and therefore there has to be a means of stopping this system from grinding ahead regardless of what local people may think. I believe this to be a very real problem. Because if you do not have something like this then the Health Service becomes the government's service–not yours and mine. We are not really going to have confidence in it in the long run unless we feel that it can be deflected from what we may locally believe are wrong paths, so one has to have machinery.

DR. SCHWEITZER. Do you feel that this system also does deflect grievances which might otherwise have gone through the regular malpractice route?

SIR GEORGE GODBER. Maybe. After all, it costs doctors in Britain less than $100 a year to insure against malpractice. It costs rather more here. I don't believe that all British doctors are free of error. I think it means that the opportunity of oversight within the Service and of complaint against the Service is likely to remedy problems at an earlier stage.

DR. CHRISTA ALTENSTETTER. Just following up on a complex subject, you developed a number of linkages between the public, the individual member, and the patient, with the system–whether it is the health system or whether it is the political system. You showed various mechanisms developed to deal with grievances and complaints at different levels of an ongoing process. I have noticed that you did not mention specifically what has been considered by classical theory of representative government to be the intermediary between the public on the one hand and the governmental system on the other, that is to say, the parties and the trades unions. Now, you mentioned at one point that there was relatively little interest in health as a salient political issue. I wonder whether you could elaborate a little bit more on those two conveyor belts between the public and the system per se, whether they really don't have any influence or no interest, whether the positions of the parties are channeled into the system already at the national level. Particularly, I think I would like to ask whether there has been or not been any bipartisan effect at those levels, such as when you talked about elected bodies representing the city government–whether there are any differences between city governments run by the Conservative Party or city governments run by the Labour Party.

SIR GEORGE GODBER: I do not believe there is any real political difference. I don't think there was in the days when elected local government had some direct involvement in health care, except perhaps that Labour local

governments were more ready to spend money but had less to spend, and the Conservative Governments perhaps were less ready to spend money but had more to spend. It balanced out.

I don't believe that politics on any scale come into the operations of the former hospital authorities or today's health authorities, although I do think that people sometimes became members of these authorities with a sort of crusading zeal for preventing the poor patients from being ill-used by the Service, as it were—but they were apt to find that there was no real justification for that sort of attitude.

I say this because I can think of a few cases where, because of this political background, there were individuals who behaved in a rather upsetting way in regional health authorities. They had remarkably little support among others who really knew what was going on, but it doesn't follow they were always wrong.

Sometimes trades unions have come into this to emphasize what they may feel to be inadequate service given to a member, but not routinely. You see, they were represented in the authorities, represented in the sense that there would be a trades union nominee chosen to be a member of an authority.

There is one issue where one gets the party difference and that is the one that has caused so much trouble over the last 2 years; whether there should or should not be provision for paying patients in the hospitals. At the moment, something like 2 percent of admissions to hospitals are of paying patients—or they were up to a year ago. There is no doubt that within hospital staffs other than medical there was a great deal of disquiet because they believed that some of this small group were obtaining advantage in the timing of their treatment over the ordinary person. They felt that this was basically wrong.

The Labour Party has quite clearly indicated that it is for the abolition of pay beds. The Conservative Party is against this. I can only quote an article from yesterday's *Washington Post* which mentioned that Mrs. Margaret Thatcher, current leader of the Conservative Party, had said at the Conservative Party conference to doctors who threatened to emigrate, "Stay with us and fight socialism." That seems to me the kind of slogan that the British Medical Association would be very ill-advised to take up.

MR. MORTON A. LEBOW: You mentioned, I think, that the Ombudsman had handled some 500 cases? And some of these were inappropriate?

SIR GEORGE GODBER: I believe that was the number. I am sorry I haven't got the exact figures.

MR. LEBOW: It seems like a surprisingly small number.

SIR GEORGE GODBER: To be inappropriate?

MR. LEBOW: No.

SIR GEORGE GODBER: Altogether?

MR. LEBOW: Altogether.

SIR GEORGE GODBER: I wasn't particularly surprised by these figures. I couldn't find them to quote, and I haven't got the Ombudsman's annual report. Therefore, I may be wrong about the numbers but I believe not too far wrong. I think that the handling of most complaints about the Service is reasonably done, and staffs are aware that it is of no use to sweep these things under the carpet. When people express a grievance there is a reason, even if it is not a good one. If one wants to run acceptable health services then one has to try and find why there was a reason and how to remove it. But really, perhaps I ought to offer to get a copy of Sir Allan Marre's report.

MR. LEBOW: Well, if it is the same scope it doesn't make any difference; but a number like that makes it very encouraging.

SIR GEORGE GODBER: Well, I am not discouraged about the Health Service except that the government doesn't find it enough money.

DR. MILO D. LEAVITT: Are there any other questions for Dr. Godber or Mrs. Godber?

DR. COHEN: If you could comment on the article which appeared in *Private Practice.*

SIR GEORGE GODBER: Oh yes. This is the article to which I referred, about the attractions for British doctors of incomes obtainable in medicine in the United States. Well, there are some who would be attracted. Dr. Quinn recently gave me a press quote from the Consultants and Specialists' Association who said they had polled 2,500 of their members and 300 of them were actively considering emigrating. The Association's members, as I recall, number perhaps three times that. This is the way they conduct their polls: they poll the lot, and have replies from about 2,500, of which 300 irascibly wrote that they were considering emigrating. Some of them might have been 65 and retired, others of them might just have been taken to task for something which made them at the moment more than usually irascible. If 10 percent of the 300 ever emigrate I shall be surprised, and I would almost be prepared to say, you are welcome to them. The statistic as it stands does not mean an awful lot. But there are real grievances among doctors at the present time. I am not concealing that. The remuneration of doctors in Britain is lower than in Western Europe generally and a great deal lower than here. The higher levels of income have been subject to a stop in further increases quite recently, but in our general financial situation it is perfectly intelligible that the higher-paid doctors, like the higher-paid civil servants, or anyone else at that income level, should for the moment forego further increases in their remuneration.

Although the Secretary of the British Medical Association is quoted as saying, "You can understand if people want to go where the grass is greener," I don't believe that it is going to attract a great number of people. I think people will come to Canada, Australia and the United States, because a minority of British doctors would like to feel able to earn substantially larger incomes by private practice. But I don't believe that this would draw very many of them.

There will, of course, always be an overseas attraction for some people who might seek and not get, for instance, academic advancement in Britain. I believe that our faculties have not had enough posts in a

good many fields. A son of an old friend of mine went to Canada as a professor of hematology. Had there been a chair in hematology he probably would not have left Britain, even for the double salary and better facilities that he got when he went to Canada.

So, because of the present bad relationships between the British Government and the doctors, we may lose a few more doctors a year than we have been losing. I don't think we will get a mass exodus. I believe we are going to have rather unhappy relations between government and doctors for some years to come. This government is ideologically committed to removing pay beds from hospitals, and is motivated in that by the fact that a few consultants have abused the privileges and undoubtedly did try to encourage public patients to obtain earlier treatment by going to private sources, of which these were one. It caused tremendous indignation where identified. It caused the greatest indignation among nurses and other hospital workers, including junior doctors. The vast majority of physicians have just worked hard and conscientiously and exploited no one.

So I would not put up panic signals on that article or on those sources of information, but the position is not a happy one at the moment.

DR. JERRY SOLON: There seems to be a standard tendency when you develop these councils, consumer type groups, for a polarity to develop in the whole atmosphere. A posture is assumed that is divisive. What are commonly heard are grievances and complaints. That seems to be their function and activity. I wonder whether you have seen signs of a more colleagueship type of approach in the climate, or the potential for it? This is related to what was remarked here about the planning function as against the reactive function, usually negatively reactive. I daresay, too, that there are instances where physicians and other health staff have grievances against patients. Is this the kind of a body that can assume the role (which is more resolving of difficulties and looking ahead and improvement-oriented) regardless of whether there are complaints or not?

SIR GEORGE GODBER: I doubt whether it will deal very effectively with the individual complaint. It will help the complainant who doesn't know what to do. It will put him onto the right paths. If the professions and management use these bodies sensibly I believe they will produce better relationships locally. If their attitude is always one of withholding information and "keeping them off the grass" if they possibly can, then they will only embitter relations. It is a question of whether both sides are going to behave in an adult fashion. But the kind of polarity that you are describing is possible. It is too early to say whether this is occurring. It may occur in odd places; in fact, I have seen signs of it in odd places. But we must wait 2 or 3 years to see whether those problems work themselves out. My belief is that if these things are not made to work, then we enter a phase of unrepresentative management of health services, which could lead to bad feeling. On this, I can only say wait-and-see.

DR. LEAVITT: Sir George and Lady Godber are off to Philadelphia this afternoon, where he is to become a visiting professor at the University of Pennsylvania for the next 3 days.

COMMUNITY MEDICINE AND THE PLANNING PROCESS

DR. MILO D. LEAVITT: This afternoon Sir George is going to discuss community medicine and planning with us. We look forward to your comments, Sir George.

SIR GEORGE GODBER: Thank you. Community medicine as I am interpreting it for the purpose of this afternoon is simply a medical specialty concerned with the problems of the community rather than of the individual. This term tends to get used in a variety of ways, describing anything from ordinary general practice to the sort of specialty about which I am talking. But it seemed to me that I should spend most of my time talking about planning within the Health Service, and then try to show how community medicine, as we are developing it in Britain, fits into this.

When thinking about planning for health, one has to start with the proviso that this involves two different things. One can either plan interventions about particular aspects of health or one can plan a comprehensive health service—and the two exercises are different. When planning for a comprehensive health service, one has to think very seriously not only about what the individual component costs, but also whether the cost can be met from within the resources available for a comprehensive health service.

That is the position in which we have been in Britain since 1948. Before that it was possible to have, for instance, a Cancer Act which made it possible for local authorities to draw up schemes for the treatment of cancer. But today this could not be done separately from schemes for the provision of comprehensive health service. The trouble with the comprehensive health service is that anything beyond the research and demonstration stage that can be done effectively for anyone within it has also to be made available for anyone else with the same needs. Therefore, the capacity to meet any particular need is at once circumscribed.

The first point I would make is that we do not start with a blank sheet. This same point was made by Basil Hetzell of Australia in a lecture to the International Epidemiological Society in Baltimore last year. We start with by far the greater part of all of our resources committed in a way to which the professions and the public are already attuned. It is not possible to look at what one is doing and say, "We will omit that, and we will omit that, and we will do it this way in the future," because the instruments with which you do it are so very numerous and so very willful, if they are in the health professions. One's object has to be achieved not by stealth but by a gradual process.

The occasions upon which one can launch out on something quite different from what has been done before are exceptional. For instance, even the arrival of a drug such as L-Dopa for Parkinsonism fitted well into the overall drug therapy picture—even though it added an extra £10 million to the National Health Service bill the first year it was fully available. The money had to be found somehow, but the method of using the drug fitted into other forms of therapy, and one could not really regard this as planned introduction. It was introduction because the drug was available, but the plan that had to be made

was to provide the extra money—which in fact was done—or else one would have to stop doing some other thing in order to obtain the L-Dopa money.

Once a service is established it is not very easily withdrawn, for a number of reasons, the first of which, of course, is public conviction that it is valuable to have it. It is not possible to move in the teeth of public belief that something that one has been doing for years, maybe, is of value to them.

One is always affected by past political advocacy. For example, during World War II we provided vitamin concentrates for small children in Britain, free, as an essential contribution to their nutrition, in a rationing situation which involved a lack of citrus fruits and a lack of fish. Once the politicians are really into advocating this type of thing, being a great public good, don't ever believe that one can get the Minister to announce suddenly that "It may have been good yesterday but it is not today."

In Britain we went on providing orange juice, as a vitamin C supplement to children, for at least 15 years longer than any nutritional reason would have justified it. When we did slowly pull it out from our schemes, the government of the day had to endure a battering from the other side such as you would hardly believe. Science does not rule the battles of politics; rather the expediency of the moment bears on a thing like that. They have a point, of course, that public belief may be at stake.

Then again, the arguments may be marginal. When we, simultaneously with the United States, stopped doing smallpox vaccination as a routine for infants, we had considerable trouble with those who did not believe we were justified, including some members of the profession. They would write letters to me saying that we were monstrously ill-advised in exposing children to risk of future death from smallpox. It soon died away, but protest is a factor when change is contemplated.

When cholera came into Europe, there happened to be a new government in Britain, and the Minister of the day naturally asked, "What can we do to keep this out?" The answer, of course, was that fuss was unnecessary. Water supplies were secure, and there was not going to be an epidemic spread of cholera. Thinking one can stand at the gate of the airport and keep cholera out may be a political illusion; it is certainly not a medical one. Nonetheless, it was required that people coming into the country had to have been vaccinated against cholera. Whether that increased or reduced or made no difference to the risk of importation of cholera, I wouldn't like to say. It certainly cost a lot and caused a lot of people to have injections and it may have helped public confidence. Once having done it (and it was done in such fashion that the government could be seen to be doing something to keep this terrible danger at bay) it took about 4 years to get it undone. That is the sort of problem one runs into since politicians understandably do not want to be seen to be shifting their ground once a year. Would they be credible on more important matters if they did?

Then, of course, there is the kind of opposition one can get from commerce. It is necessary only to think about the cunning way in which cigarette interests have circumvented everyone over the abolition of the most dangerous regularly-used practice by a high proportion of the population every day. And then there are the fanatics. In the United States, about 30 percent of the population has fluoridated water supplies. In Britain fewer than 10 percent have it, and this discrepancy is due simply to the fanatical advocacy of pure, (supposedly pure) water by a small group believing every bit of ill-founded,

scientific comment on the risks of fluoride, but none of the carefully documented evidence that fluoridation is not dangerous.

Additionally, there is the public desire to indulge in alcohol, which is another needless drug—to me, anyway—or for that matter, in eating too much, as I do myself, therefore reducing my level of health. There is also professional conservatism. Hospital procedures, for instance, tend to go on from habit rather than from careful close scrutiny of benefits. You may remember that the discovery that it was unnecessary for women to stay a fortnight in hospital after having babies was made in the United States, during World War II when the birthrate had reached the level at which the beds for such a long period of stay could not be provided. Most of you may perhaps not remember, but it was the common practice in both our countries for women to stay 10 to 14 days after confinement. The finding that it was not only expedient, but actually valuable for them to stay a very much shorter time, as they do now, was made quickly in the United States but it was most difficult to get across in Britain. In the late 1950's, we had an expert committee inquiring into British maternity services. The committee's published report solemnly said that we should adhere to our 10-day stay after delivery, with the committee not even noticing that the average was already down to 8 days before they had published their report.

The length of stay of patients after surgery can become extremely important in planning, because one can have a group of surgeons firmly announcing that patients after a herniorraphy ought to stay no fewer than nine days. Not 8 or 10, but 9—and yet their colleagues in the same hospital are sending their patients home after 5 days with no worse results. It takes literally years to bring surgeon A to see that he has, without noticing it, accommodated himself to the practice of surgeon B and is only keeping his patients 5 days, and it hasn't in fact done them any harm. But he has not lost face in the process if it has taken him 5 or 6 years to reach that point. All that has happened is that a tremendous amount of hospital and patient time has been lost.

Then there is the professional insistence on freedom to prescribe, and there are still issued within the National Health Service many prescriptions a year for chloramphenicol for children for conditions that certainly don't need chloramphenicol, prescriptions that certainly do expose the children to a risk of aplastic anemia.

Further, in our Health Service we have had the vehement opposition of the dentists to the second-class dental service that might be provided by the employment of auxiliaries—even though, in fact, they would be treating patients who would not be treated at all if it were not for the auxiliaries. Although there is the example of the dental-nurse scheme in New Zealand providing thoroughly satisfactory service to school children, the dentists will stick to their line just as firmly as the doctors to theirs.

Since we are discussing other professions, how about the nurses? In Britain we have been 25 years in trying to introduce a standard nurses uniform. Do you think that is possible? You try. Then the demarcation disputes between the specialties in medicine. The general surgeons who are quite certain that they can do urology as well as the next man, and who with equal certainty will go to urologists to have their own prostates removed in due time. And the general surgeons who are fond of children and so keep the pediatric surgery in their own hands, which will ensure that more children die, but nonetheless they demonstrate their care for children, according to their own lights.

Similarly, we still have a few senior psychiatrists in charge of large mental hospitals who proceed at the doddering pace appropriate to 20 years ago, before people had realized how very much better one could do for the psychiatric patient. Prompt treatment in the early stage of mental illness, without detaching the patient from the world in which he normally lives if you can possibly help it, and appropriate use of the newer drugs can greatly shorten stay.

Then there is the trouble that arises from fierce local loyalties about, for instance, small general hospitals. Someone whose grandmother collected the money to build the cottage hospital in the small town will defend it at all costs, because he or she was old granny's favorite. But if he or she has a major condition that takes him into the hospital, the small local hospital is not the first choice and should not be. This sort of person always is supported by some local members of the profession who may have other vested interests in a hospital they staff.

There is, of course, the opposite situation, the extravagant development that someone wants to start in a particular hospital because they have heard, say, that radioactive cobalt units are good for treating cancer—so there should be one in the local small general hospital. Their favorite aunt died of cancer last year, and if only this cobalt unit had been available in the local hospital, that need not have happened. At least that is the way the argument goes. This sort of person may well be ready to put up £50,000, or whatever it may cost, as if these things weren't confoundedly dangerous if not kept in the hands of people well able to use them.

A much commoner and more easily understood example is the small hospital in one of the Welsh mining valleys with an accident and emergency department (and heaven preserve me from going in there with a broken femur or whatever it may be. I don't want to have one of those anywhere, but if it does happen, certainly not in that place). But it is just down the road and, it will be said, the ambulance should not go past it to the hospital where one might be competently treated, 10 or 15 miles away.

Then, there is in general practice, the single-handed doctor in a village who is readily available to anybody—unless he happens to leave the practice in the hands of a deputy living in the village 10 miles away over a weekend. But in any case he is the local doctor, and so patients are trying to keep him there single-handed rather then having him move into a health center with a group of other doctors 3 miles away, where service could be obtained at any time. (There are so many cars in British villages nowadays that transport cannot be too great a problem.)

Then, there are the repercussions of some of the services on others—for instance, the management of the mentally handicapped. Too many children and adults have been kept segregated in hospitals for the management of mental handicap, missing the sort of educational advantages they could have had if training centers had been established outside the hospital, with hostels being used in the absence of suitable homes.

Then, in geriatrics, proper planning certainly involves far greater use of good hostel accommodation, because since continuous medical and nursing oversight are not provided, management ought to be less expensive. Planning should also encompass providing domestic help in the home, or delivery of main meals to

the home to help maintain nutrition in the elderly, which is, after all, one of the great problems. There is also, in geriatrics, unreadiness to accept the advantages, either to psychiatrists or to geriatricians (let alone to the patients who benefit most) of the new specialty developing in Britain, psychogeriatrics.

Thus there are all sorts of obstacles in existing services, especially once one has an established general service, that mean that the changes devised rarely sweep across the country. They nearly always involve the molding of existing practice and slow development, possibly with capital investment. But for all that, there have to be long-term strategic objectives, and these are not obtained first by sitting in an office, cerebrating in London. There has to be a systematic infusion of ideas from outside the professions and from the general public.

Once one has developed long-term strategic objectives with assistance from outside, then a central department is needed to disseminate them and impress them as advantageous on the Health Service regions or districts. One good example is the development of the hospital group in Britain. When we started in 1948, general hospitals were grouped together, the psychiatric hospitals fiercely defended their independence and were grouped separately. This must have had a considerable inhibitor effect on the development of psychiatry in the first 5 or 6 years. Since then that has changed under guidance from the center, and psychiatric hospitals are usually grouped with the general hospitals and the development of acute psychiatric units in general hospitals, and the gradual running down of the old large mental hospitals has become possible. But this followed local development, especially in one region.

Then there is development of the specialties. I mentioned earlier that before the service began we had a group which produced guidance on the way in which specialties in the hospital service might be developed. This guidance was published even before the Health Service came into effect at the beginning of 1948. This was seized upon so enthusiastically by the hospital authorities that they began to run through their allotted money at much too fast a rate. Therefore the whole country was reviewed by teams recruited in 1950, mainly of senior consultants or recently retired consultants, who gave their views about what should be the specialty staffing in different regions. The outcome of this was comic, because the different recommendations had such bizarre differences between themselves that it was quite impossible to make them public with confidence then or since. So the teams were quietly stood down, and instead a central committee was set up to review the different regions, and the recruitment of specialist staff, and to keep a check particularly on advanced training posts in the specialties. That committee ran for 20 years until it was replaced by a remodeled committee about 5 years ago. Although in that period it must have made at least 2,000 decisions, I don't recall that it ever had a vote taken. Despite its being comprised partly of representatives of the profession and partly of representatives of the department, it managed to be unanimous in its conclusion on every occasion.

You may recall that around 1952 there was an epidemic of poliomyelitis in Denmark, with a large incidence of respiratory paralysis. One of the first clinical planning conferences that I recall being summoned was concerned with the provision of artificial respiration in cases of respiratory paralysis. It brought together representatives from each region of the group of people concerned, and produced recommendations about what should be done to make available positive pressure respirators throughout Britain. They were provided, and it

remains one of the few examples of deciding on a particular course of action and putting it into effect generally over the whole country. But this is, after all, a trifle in the middle of the large mass of clinical practice.

We were responsible from the center for promulgating the plan to produce group general practice but it was in accordance with professional advice. We were able to get some assistance, as I described on an earlier occasion, from the additional monies made available for general practitioners in 1952 and 1953. We were able to launch the Health Service on a plan of promoting grouping in general practice that was to come to full effect after 1960 as confidence grew. This is the sort of time relationship with which one deals. It cannot just be announced that group general practice is the right way to have general practice, with the expectation that everyone will move into groups in the course of the next year. One has to obtain conviction within the profession, and one has to provide the facility that is going to be used.

As an example of how badly policy can be determined centrally, I recall that we had a committee to advise on the probable requirement of medical practitioners in the Service, a committee under a former Minister of Health, Sir Henry Willink. The committee made the most disastrous miscalculations to the effect that whereas we had had, at our maximum, something like 2,200 British medical students going into the schools each year, this should be reduced to just over 1,700. It was but 3 or 4 years later that the error was surreptitiously remedied—without there being an officially announced policy until the Todd Royal Commission on Medical Education made a different recommendation 10 years later—one on which we have been working ever since with planned development of the medical schools. The Royal Commission recommended that we should reach a 3,600 intake by 1975 (we just did), and to 4,100 by 1980. The method of forecasting was a little odd. A graph was drawn of the increase in the number of doctors, it was linked with an anticipated increase in population, the straight line was extended and this said we will therefore need so many doctors in 10 years' time and so many more in 20 years' time. That is not a very scientific method of planning, but it is the sort of thing that is apt to be done.

The change in psychiatric practice mentioned earlier was endorsed by a Royal Commission which considered the whole field of mental health in the late 1950's. Their recommendations were enshrined in a Mental Health Act in 1959—remarkably quickly, in fact, only 1 year after the Commission finished its deliberations. I cannot imagine that the new commission on the Health Service, now to be set up, will be similarly fortunate.

Perhaps one of the best exercises in long-term planning was the Powell Plan for Hospital Development, also mentioned on an earlier occasion, which was published in 1962 and was compounded of the plans made by each region within certain general guidelines provided by the department. This provides for concentration and replacement of buildings within an existing hospital service, and for a reduction in the bed provision in the process, because it is believed that the single district general hospital will be more efficient and will manage on a smaller allocation of beds.

At about the same time, it was decided to give priority to postgraduate medical education, because a voluntary body, the Nuffield Provincial Hospitals Trust, called a conference of leading figures in the profession, including the Permanent Secretary of the department and myself (then, as Chief Medical

Officer) and came up with recommendations for the development of postgraduate medical education. The recommendations in broad principle are still being followed through. This is an example of something being introduced, proving immediately acceptable to the whole profession, and being promoted by the provision of additional funds. But the important thing was that it was acceptable to the profession. It would not have been implemented otherwise, because probably one-third of the money required for providing the new centers was subscribed by the profession itself, one-third collected from charitable sources locally, and only one-third provided by the health department. But the plan was a central plan, and it was promoted further by the follow-up action by the department, and the full cost of maintenance was taken on by the National Health Service 2 years later.

In the hospital plan had been included the idea that there should be an acute psychiatric unit in each district general hospital, and also a geriatric department. That sort of general principle was then imported into all the local planning by hospital region. After the hospital plan came the plan to develop community care, and that provided guidelines for a different lot of local authorities, those responsible for welfare and personal preventive services in the community. This has been very largely the guiding pattern for the whole of the country ever since. It provided certain basic minima suggested as the target for each authority. But, there, one was seeing only the best current practice given expression in a plan which the local authorities were urged to follow. Shortly after this, we began to get more direct intervention to promote greater concentration on some of the services that admittedly were lagging behind. For instance, in 1964, Mr. Robinson urged priority for geriatrics. Geriatric medicine is not, I think, a specialty met with widely in the United States, but it is the common form in Britain. The care of old people in Britain's hospitals is in the hands of physicians who specialize in it. It is not that it is technically particularly abstruse, it is, perhaps, internal medicine played slowly with a strong social bias. It does not enter nearly so deeply into much of the technical medical work that the ordinary internist does, although in fact one-half of the admissions to ordinary wards under the control of internists today are people aged over 65, but they usually have acute episodes for which they need only short stay.

Another service, the provision of treatment for trauma, called for concentration on selected hospitals. It was not for everyone to attempt in units not having a constantly-available staff skilled in that sort of work. By and large, the accident services have been thus concentrated (although we have run into the sort of thing mentioned earlier in my example of the unit in the Welsh mining valley, where we even had threat of a local mining strike to avert the closure of a unit which could not be kept open in an efficient form).

I have already mentioned the special priority for mental illness, but Mr. Crossman came along after Mr. Robinson to emphasize the inadequacy of services for the mentally handicapped, and to arrange for a disproportionate use of the funds available for development in order to improve those services.

End-stage renal failure—you have your own special scheme in the United States, we have a smaller one in Britain. I believe we have no more than about 2,000 patients on dialysis, but we have had facilities of that order for the last 10 years, the reason being that government deliberately decided to put money into a service, planned on lines recommended after a central professional

conference, and had set up a small committee to advise the department on how regional units were to be developed. A similar process was gone through in order to control the development of coronary care units, equipped with exceedingly expensive equipment, which might otherwise have been scattered over all the hospitals with quite inadequate results for the patients.

In the middle-1960's, health centers began to appear rather than merely group practice centers. Health centers provided by the National Health Service not only because they had been recommended from the center, but also because negotiations about remuneration had made the health center a viable thing for the general practitioner. His remuneration was in a different form, and he could afford to pay the rent that a health service center would necessitate.

I have mentioned the unplanned effect of the arrival of L-Dopa on the drug bill, because suddenly we had something useful in Parkinsonism, where we had not before. There have also been periodic attempts to control the drug bill, which is something easily visualized by politicians, and they can always see that it must somehow be wasteful for 10 percent of the Health Service expenditure to be devoted to providing drugs. Well, I think our drug bill is lower than the drug bills of most other countries that try to make a general provision, or even a limited provision, of drugs—especially expensive and necessary drugs. However, attempts to control the drug bill end, if they get anywhere at all, in attempts to improve the education of doctors about pharmacology, because there really is some waste. Of course, that has to be done, as far as possible, indirectly through the ordinary educational machine.

One can introduce something entirely new in the preventive sphere—for instance, whooping cough vaccine was introduced under the National Health Service, and later poliomyelitis vaccine. The switch from Salk to Sabin vaccine, measles vaccine, rubella vaccine, the general use of tetanus vaccine—all were introduced under the National Health Service. And the negative procedure of not planning to have general use of influenza vaccine has also been accomplished, simply by getting expert advice and promulgating a departmental view and not paying general practitioners extra for doing it.

In the early days there was pretty tight planning control over new buildings. That has been substantially relaxed because the early work of the department's own planning unit had a considerable educational effect on the hospital regions, but the introduction of what was called the "best buy" hospital—a compact, inexpensive hospital designed to be run in close relationship with community care using the smallest practicable number of beds and shortened stay—was a central exercise which has been eagerly taken up by hospital regions wherever they could get one.

Then, we have aimed at improving local professional organization. Some of you may be familiar with the Cogwheel reports which suggested the way in which doctors might organize their own work in hospitals. These were produced by a working party which sat on-and-off over a period of about 6 years, with the older people dropping off at the top and some younger people being introduced at the bottom, with considerable advantage in the third report: That happened to hit off a favorable reaction among the profession, and they, recognizing means of assisting their own work, have pretty generally adopted a different pattern of professional organization in the hospitals from

anything that had existed before. It may have been hampered by reorganization, but it is still there.

A similar committee, the Sammon Committee, rather differently made up, considered nursing structure. It was also responsible for suggesting a change in the administrative structure of nursing. This was first demonstrated in a number of pioneer projects in particular areas, and then generally applied when found to be effective. It was not immediately promulgated and enforced. Earlier still we had a central system for training hospital administrators, devised largely with the help of another voluntary body, the King Edward's Hospital Fund in London, which provided a central college, but then enjoined on the hospital authorities peripherally. The result was an intake of younger, better-trained men into hospital administration, with benefits that are beginning to be seen more clearly as some of these people come up to leading positions in Britain's hospital administration.

I was interested in finding that one of the earliest products of this scheme is now, unhappily for us, enlivening the scene here in the United States. She is Rosemary Stevens, who told me that she was one of our first entrants into the training scheme, and whose loss to Britain I much regret.

We then had another central committee, the Zuckerman Committee, consider scientific organization in the hospitals. The ideas contained in their report were not wholly welcome to some of the pathologists, who did not relish the sort of change which gave non-medically qualified scientists equal status with doctors within the hospital hierarchy. But acceptable arrangements are being introduced.

Changes in general practice organization suggested by a working party sitting in 1973 were acceptable only because the ground had first been tilled by another working party, under a different chairman, 9 years earlier. (One seldom gets away with radical changes the first time around within a Service like the Health Service in Britain.) Then, before we tried to develop the community physician, a committee of largely younger people from the academic field, and from the public health and hospital administration field, produced a report on the need for medical administration and for the community physician, and the kind of work he ought to undertake. On the recommendations of that committee, urgent steps were taken to improve training and retraining resources, both for the people already in public health posts and medical hospital administration who were going to have a wider sphere of activity in the reorganized health service, and also to set up new courses of training for younger people coming into the field.

Also, there has been guidance on research, largely by the Medical Research Council, but in which the health departments have also played a part, and a review of the facilities for government-sponsored research in the United Kingdom, which was carried out by Lord Rothschild 4 years ago.

Regional planning, which is the level at which the centrally-envisioned general principles have to be applied, has also contributed a good many of the original developments in some of these wider subjects. The value of acute psychiatric units in general hospitals was first demonstrated in the Manchester region, and the idea was taken up centrally after that. The development of renal transplantation in Newcastle, Cambridge and Hammersmith, surgical cardiac bypass work in Birmingham, Leeds, Hammersmith, and Guy's, and the improved organization for training junior hospital staff in Oxford and

Wessex—all were pioneer efforts which were generalized only because the center was in close touch with the regions and picked up hints from there.

Building developments in other regions followed the very active pioneer work of regions like Oxford and Newcastle, and manpower and the training of younger doctors were developed best in the Wessex region. Guidance for research was developed in Newcastle, and the better control of drugs in the Liverpool hospital region. The first report produced on hospital libraries—which has been generally followed in the postgraduate medical centers—was produced by the Sheffield region.

Thus, all the regions get their chance to influence the sort of policy that is going to be promulgated from the center. Further developments within the region are mediated partly by the existence of expert staff employed by the regional health authority and partly by the professional advisory machinery which each of these hospitals has to have. In particular, they have to have a regional medical manpower committee which plans for the distribution of new posts within the hospital service, and a regional postgraduate committee which plans with the university the development of educational programs in the district postgraduate centers—particularly specialty training programs which may be run at only one or two major centers in a region for some of the specialties, in, for instance, pathology.

Consultation with the periphery by the department has in the past been with the authorities, and consultation with the public has tended to be more by the regional boards in connection with any change of plan. But it was appreciated early that to proceed with radical alterations in the hospital service without having had public consultation to explain what you wanted to do was simply inviting opposition. That kind of consultation is a prerequisite before the Minister will agree to the change of use of any hospital, and the Minister has the final word on whether the use of a hospital shall change. There is one children's hospital in London which to any discerning observer has been redundant for at least 20 years, and there were, I recall, seven separate debates in Parliament (either in the House of Commons or the House of Lords) because of the antagonism of local interests to its change of use. It seemed they would rather let it die on its feet. At the least this shows popular involvement with the Health Service and is infinitely preferable to public apathy and submission.

There also has to be consultation with the university and with medical schools. Consultation at the center takes place with the university grants committee and with the committee of vice chancellors and principals representing the whole of the university field. But locally there has to be close consultation between the regional board and the university at the regional center.

The regions produce an overall plan under certain budget subheads, within which they have certain powers, only swapping the money around from one budget subhead to another. But they have never been allowed to move money from their revenue program to their capital program or the other way around. That seems to offend the souls of the financiers almost more than anything else.

The attempts that regional authorities have made to get adequate regional shares have not been very successful, mainly because they would involve changes which the central authority would have to undertake, and if they were then to be substantial and not simply undertaken from the incremental increase of the budget each year, the funds would have to be taken from somebody else.

I don't believe anybody ever succeeds in getting butter out of the dog's mouth. The one exception to that, of course, is that if you happen to have a national Minister like the Secretary of State for Wales or the Secretary of State for Scotland, he argues at a different level and with rather more success. But within regions, a great deal can be done by carrying the experience of the best practice within the region to others, and some regions have done particularly well by having a sort of traveling seminar approach. A team is sent, say, from Newcastle center to look at the psychiatric resources in Carlisle, and they come up with a series of suggestions about improvements that could be made there and about change in practice. When they move on to the next place they are going to comment upon, they drop perhaps one of the psychiatrists in the team and pick up one of the more enlightened people from Carlisle, and so nobody feels that it is only his center that is being looked at.

Often within a region there will be not only failure to advance on the most desirable lines, but failure to reduce something to which the region is committed. A bad old sanatorium which was converted into a rehabilitation unit—when it should have been allowed to fall down or certainly should have been closed—is a good example of that. No local authority ever wants to let anything go. They always would prefer to look for some other means of using it. It would have been far better in the case cited, instead of spending something of the order of £80,000 a year to run the place, to spend £20,000 of capital in putting up a light building at the main hospital as a non-residential rehabilitation unit, and the patients would have benefitted a great deal more. This is an example of misdirected local interest interfering with planning development.

When one comes right down to local planning, the district, as I have said all through these talks, is the unit with which to build up the health service. The larger areas, which include several districts, have to plan their work district-by-district and fit the districts together for some of the services. The areas have to make sure that their planning is related to the education and social welfare and housing services of the other authorities that serve the same area, the elected authorities, and the districts themselves, have to relate to local authority districts for environmental hygiene. The personal preventive services, the School Health Service, for instance, if planned at an area level, must fit in with the district hospital and community services. The area also has financial control within the oversight of the regional health authority—the financial control and preparation of the budget for each of its districts. It also has the family practitioners' committee, which looks after general medical and dental practice and the pharmaceutical services, but it does not do much planning, except to link with the other services for the provision, for instance, of health centers. It should really be an area responsibility to plan for occupational health facilities for the staff of the area.

Economy in health services really depends on the way the district unit manages the effective use of resources, and the district unit has a district management team consisting of a senior non-professional administrative officer—or rather he is a professional administrator, and does not belong to one of the health professions—a finance officer, a district nursing officer, and the community physician, also one general practitioner and one hospital specialist. The plan that the district draws up for future activities starts with the present services and their economical continuance. It is not able to abolish services

without area concurrence. Room for manœuver is therefore quite small. It may set up, or the area may set up for the district, a health-care planning team to look at particular client needs, such as needs for the elderly, and for that purpose may bring in people from the social welfare authority, because most of the needs of the elderly are not looked after in hospital.

The district unit can adjust some of its use of funds between the hospital and the community, but it cannot use revenue funds for building purposes. It has to inform the community health council for the district and consult with it about future plans. Within the hospital, the divisions (which I mentioned as having been set up in accordance with the recommendations of the Cogwheel working party) apply themselves to the most economical use of the resources available to them. I cite as a simple example a group of hospitals doing all the surgical work for their district, or one main hospital which had, say, half-a-dozen operating theaters with a much larger number of surgeons needing to use the theaters, it may well be that one surgeon has for years enjoyed the use of those theaters on three half-days a week, and he puts in perhaps 2 hours on each of those three half-days. If only he could be persuaded to concentrate on two real half-days of 3 hours, this would free the theaters for use by somebody else on the remaining half-day. That is an elementary example of the sort of adjustment that ought to be made.

It is necessary to remember that in the British system the consultant staff is much smaller than the staff with admitting privileges. This should be easier to manage, but in fact the staff often jealously holds on to every bit of territory that any particular member of it happens to have. So this method of planning the use of resources, which must be familiar enough to you, has been a relatively recent introduction for us.

The Cogwheel divisions would, between them, appoint one member each to a medical executive committee for the hospital group, which would be consulted by the district management team on anything concerning hospital services within the group, and it would also provide members for a district medical committee. It must include links with nursing in the hospital, obviously, because it is no use the internists or the cardiologists planning together for an intensive unit for coronary care if the nursing service cannot be made available to it by the chief nurse.

The job of the area health authority, once each district has got its own plan, is to put the plans together and perhaps to produce compromises between district demands and the regional guidelines under which it is working, because each district, if it is worth its salt, will ask for more than it is going to get from the available limited budget. Therefore the districts have to be trimmed and leveled up as far as possible by the areas, so that all enjoy much the same level of service.

The area has its own medical advisory committee, with a predominantly representative constitution, broadly representative of the specialties within medicine, including general practice. The area must consult the local authority, usually through its officers, and there is an established joint liaison committee with the local authority responsible for social welfare education and the rest, which the two authorities are required to set up, to coordinate the provision of service within the area. The area, having drawn up its own plans within the regional health authority's guidelines, then presents to the regional health authority the plan for the area, and the region has to combine the area plans.

Always, of course, the area has asked for more than it can get, and that is duly trimmed back by the regional health authority.

During this process there will have been consultation with a regional team from the Department of Health and Social Security in a fairly early preparatory stage, so that the region knows broadly what its resources are going to be and, for instance, whether it is going to be able to start building this new hospital this year or whether it has been put back until 1978 or whatever the date may be.

The Department of Health then receives the regional plans, puts them all together, cuts them all because they are all quite rightly asking for more than they are going to be able to get, and then goes to the Treasury with a financial proposal in the light of these plans. Again, of course, if the department is worth its salt, its proposal gets cut because it has asked for more than is going to be available to it from the national budget.

It is all a bit like a whittling exercise, but that is the way one has to go if one has an established service and cannot undertake radical and dramatic changes. It is contemplated that this process will be gone through fairly early in every financial year. The district process will be completed, going on to the area and the region, before the budgetary allocation is determined by the Treasury. The whole process would have gone through the series of authorities and it would, as far as possible, represent the practicable application of national policies.

However, unless government is going to be able to produce more money for development each year than it looks as if it is likely to do, then there is not going to be much expensive new development for a few years to come—unless locally things are cut out, such as the disused sanatorium mentioned earlier (which could probably be cut, providing an annual saving of maybe £50,000 if capital required to make the modification to the main hospital had been spent).

It is my personal view that this procedure, as published in reports by the department and others, is altogether too formalized. It allows too little for the growth which will occur from inherent drives within the service. To me, it does not seem to recognize clearly enough that what is happening is a continuous molding exercise, and that a rather elaborate production of new plans each year is wasteful of time and money. Nonetheless, there are some things that have to be planned a long way ahead; for instance, structures. Health centers may be planned and built within a year or two, but hospitals certainly cannot, and for those, a 10-year plan rolling forward is, I believe, the only possible solution. The department did have a practice of telling authorities that they might expect to start this hospital in, say, 1976, and this one not before 1978, or this large development this year rather than 5 years hence. But that practice, of course, has been badly affected by the present shortage of funds.

Manpower development has to be planned ahead. A student entering a medical school in September 1975, if he is going to be a consultant, cannot be a consultant before 1988—and if he is going to be a consultant by 1988, it will be only because the hospital service development has been planned so that there will be an opening for him. If students all aspire to be neurosurgeons, most of them will be emigrating or unemployed. So there really does have to be fairly long-term planning for manpower use.

The process of local modification, which is the key to health service development, most needs provision for local interaction between disciplines and with people. One of the most important factors in that is that what is proposed must be an acceptable system. It must not be an imposed change; that just will not work. There have been several halfhearted attempts at imposing changes of a degree that proved quite unacceptable. I played my own part in doing unwise things of that kind. It is no good unless you can carry the professions with you, and I said professions, not singular profession. Each of the professions, of course, thinks it is singular, especially the medical profession; but indeed one has to carry them all.

In this system, what is the importance of the new specialty of community medicine? It is clearly needed at the center, at the region, at the area, and at the district, because at each of those levels, suitable information has to be collected and put into intelligible order for the other people, whether they are non-professionals or specialized clinicians who tend not to look at figures, or if they do, not to understand them. The group now working in this area in Britain has roots of various kinds. Possibly more members of the group come from old-style public health and preventive medicine than from any other medical field. Some grew up in regional hospital board administration, but not necessarily the administration of individual hospitals. For example, the present Chief Medical Officer in Britain, when I first met him, was the senior resident in a teaching hospital in London, and I thought he was so much better at debating points with me than were his senior clinical colleagues and the non-medical administrator, that I was able to persuade him that he should go to one of the regional hospital authorities. He is a classic example of the quality of man one can see "learning on the job." But of course that is not an entirely easy process, and particularly it is not easy for people in the clinical field.

Today, therefore, we are trying to recruit good young graduates and to pay them for training in administration and epidemiology, and the other pieces of knowledge that they need for this kind of job, just as we would if they were going on with clinical training. In a health service one can support people in training grades like that. We have courses based on the London School of Hygiene; on a consortium based on St. Thomas's Hospital; on a provincial consortium of which the key points are at Oxford and Cardiff; in Manchester in what was the School of Public Health; and in Edinburgh. There also is a sort of forcing retraining school linked with the London School of Hygiene and run by Roy Acheson, whom some of you may know from his time at Yale.

The largest number of these people will be needed in districts, because there ought to be at least one person with this kind of training in each district, and almost always there will be at least two. Their job is not to tell their clinical colleagues what to do but to look at what is done, to look at the needs of the area, to bring together the health criteria that one has in the ordinary vital statistics of the area, to try and make evaluations intelligible to the clinicians who normally do not think in community terms. Some very good exercises of this kind were done, for instance, by Bill Edgar when he was Medical Officer of Health of Northamption. He produced a plan for the development of growing Northampton and for the provision of health services there. John Reid, too, when he was in Buckinghamshire, did fine work toward the provision of health services in the new town of Milton Keynes.

The people we are training also need to have some knowledge of the new and the old prevention. There is a danger in this that all of us are so keen on organizing personal health services at the district level, that we forget that there are things like the enteric infections—which can suddenly emerge out of a contaminated can of corned beef from South America or somewhere else—and that you have then to deal with an epidemic of a communicable disease, even if it is so rare that most of the present community physicians have never seen one. Some of the trainees have to be trained in that sort of discipline. Some of them eventually must be able to advise the district local authority on environmental hygiene questions, which used to be inherent in public health and are now familiar to very few medical people in a country with developed services such as the United States or Britain.

The area needs people with this kind of training for formulating the area plan, for running personal preventive services, for seeing that well-baby clinics are established or progress, for operating the School Health Service, for linking up with general practice through the family-practitioners committee, for linking with nursing services, and for linking up with social welfare and education. At the region there is a rather different level of planning that includes: The overall planning for specialty development in the region, putting the area plans together; the special problems of manpower, the problems of education and training in the different medical specialties working with the postgraduate dean; the planning of buildings (which is not a medical exercise but an exercise that must have medical participation), and the very difficult art of presenting the region's needs to the Department of Health and Social Security—knowing the questions they will ask and providing them with the appropriate answers. This may be akin to politics, but it needs considerable knowledge of the professional disciplines, too.

The National Health Service does need central departments, even though many of the clinicians talk as though they would like to do away with them. The central unit does have to study the National Health Service in depth in all the fields, and it has to have a greater range of expertise than any other level—because it has to have really authoritative people in each of the branches to which the community physicians at district, area, or region level will come for the latest information in Br[illegible] and other countries. It has to link up with medical education; it has to deal [illegible] problems like nutrition (which are only to a very small extent, the planning concern of the lower levels), it is also responsible for the safety of drugs, for research into prevention in some of the new environmental hazards (like the one that recently broke in the American press, about nitrosamines in bacon—we had that one about 4 years ago). That was one of the occasions when I remember having to go and see three Ministers in the course of one morning. The Minister of Agriculture to advise what could be put out quickly in a written answer to a question in Parliament which would forestall an alarmist rumor in, say, 2-months' time, and the people in the Department of Environment with their problem about nitrites in water, which came up at the same time. The Secretary of State for Health and Social Services had to be told that he was not going to get an epidemic of liver cancer because of minute traces of nitrosamines in fried bacon. The central department has to have the experts who can provide that information.

There is one thing I have not yet mentioned and this is absolutely crucial to planning—one has to have understanding among the clinicians, among the

nurses, and among the administrators. There has to be training which has some common content with that of the community physician, for senior nurses, for administrators, and for some of the clinicians. The clinicians are people who use and sometimes waste very expensive resources in hospitals—unless they can be made to see that if they obtain their new gadget for measuring the annual rate of growth of toenails or something like that, at enormous cost, then they or their colleagues will not be able to have something else.

Well, I am not sure that the foregoing was what I was billed to produce, but it seemed to me to be the best presentation I could make of what has been going on in this area in the British National Health Service.

DR. MILO D. LEAVITT: Does anyone have any questions of Dr. Godber?

MS. ANNABELL CRANE: I am curious to know the background, how it was decided that someone who was already trained as a physician would definitely be needed for this position, or was that not debated at all in the Service? Was it just assumed that one should start with physicians and then add epidemiology and other skills to that?

SIR GEORGE GODBER: I think it was glanced at and not seriously considered. You start, of course, with a lot of people who have done old-style public health. But if you do look at it seriously and wonder whether you could give the needed epidemiological training to non-medical people, the answer might be that you can give some of it. But even the greatest of them all in Britain, Sir Austin Bradford-Hill, would not believe that he could do his part of it without somebody who was aware of clinical implications, knew where to go for the best clinical advice, and could interpret it when he got it—because clinicians tend to give their advice in Delphic form which will be right, whichever way the coin falls, and they therefore have to be interpreted. In getting advice from a committee of experts, you may need to say, "I think you mean thus and thus," coming down firmly on one side of the fence, if that is appropriate.

One may have to formulate that sort of guidance in order to get a clear view. I believe that you will not get the best of formulation unless you have people with something of all these disciplines in their background. Certainly, in my experience, the great exponents of this sort of thing have been people like Richard Doll, who worked with Bradford-Hill in elucidating the smoking and lung-cancer business. One can get a long way without medical training, I agree, and one certainly will not get as far with medical training if one does not have the really high-powered exponents of the mathematical and other disciplines. I believe one has to have a foot in both camps. I am just saying what I think; I am perhaps not advancing very logical reasons and I emphasize that I see this as a partnership, not an autocracy. You do need the medical input.

DR. GORDON HATCHER: I think the issue arises there as to whether comprehensive health planning, as they would call it here, is entirely or very largely institutionalized within the management of a national health service of a health department that also runs a health insurance program, or whatever you have, or whether it is institutionalized largely outside of the health department. I have done a fair amount of work in New York State with comprehensive

health planning, and we had three of them, three health planning agencies in each region, and I believe none of these agencies was headed by a physician. It was partly because they were outside of the health department and wanted to stay separate from it that I think they chose to have non-physicians.

SIR GEORGE GODBER: I am not arguing against a place for non-physicians. But when you have a health service which is concerned not only with the way in which you use your available resources for health care, but also the way in which you organize yourself to deliver care, you are in a different situation from that in the United States, where nearly always you are considering how you can arrange with bodies that provide a certain kind of health resource. In Britain we have the two things welded together, perhaps more closely than here, and the National Health Service is really economical, because the professions have chosen or have been persuaded to work in particular ways.

I think it would have been quite impossible to get some of the intraprofessional changes that have been necessary without having members of the same profession talking to them. I hold very strongly that you should not, for example, have doctors telling nurses how to nurse, or doctors trying to deal with the financial problems. They are probably not nearly so good at it as people who are trained in such matters. But I do think one gets the best results from a multidisciplinary exercise, and when I was talking about the health department, you remember, I emphasized that there isn't just one head in the Department of Health and Social Security—there is a senior administrator who is responsible for the office; he has a twin half a step behind who is responsible for the social security side of the office; and he has a medical twin, if you like, responsible across the board for the inclusion of the right medical considerations into what the department does.

I believe that the United States prefers to have the single executive head. At least it does, so far as I know, in its agencies. We quite deliberately go the other way in our Health Service. It is unique in the British National Health Service, in the British Civil Service, this particular situation. But we do not find it difficult to work, and we don't think that anything would be gained by a formal decision that one or the other was the top. I would not have liked it so. Once, in a meeting, I was asked by the head of the Civil Service whether I thought that the positions should be interchangeable, and I said, no, that I certainly did not want to exercise Philip Rogers' functions, that I was content to be the senior doctor, and that we worked together amicably in that kind of arrangement. We certainly did work amicably and, I hope, effectively.

DR. EUGENE GALLAGHER: I was wondering whether you think that in a more centralized scheme such as the Health Service in Britain, there is perhaps less need for planning as a distinct activity from administration, but where you have a looser setup like there is in this country, it seems as if more effort goes toward something called planning?

SIR GEORGE GODBER: I believe this is certainly true, because you are looking at what Enoch Powell called Leviathan, but it is an organism. He called it Leviathan because he meant that it really couldn't be steered. But it is an organism; a growing structure with a life of its own, and one persuades it in certain directions. We don't say we will chop that bit off and put something

..else there; it cannot be done. There is even the question of what happens to all the people who work in that particular service now. One could, I suppose, say. "We can't afford the dental service anymore." You wouldn't get away with it politically, and I don't think you ought to get away with it on health grounds, either. So the British setup is quite different from the American because here the planning is for an intrusion into a market system. In Britain it is not, and one is dealing with a fairly complex system. The Wellington bomber in World War II had what was called a geodetic construction, with a number of small elements, almost like wickerwork, bound into a whole. The Health Service is like that—one strand cannot be pulled without the risk of unraveling the whole thing.

It can be slowly modified over time. There would have to be a surgical amputation, like cutting off the dental service, or cutting off the decision to provide free spectacles, or hearing aids, or whatever, to make a dramatic, sudden incursion into the financing. One could do that, because what one would really say is. "Look, we are not paying any more for spectacles. You old people who cannot afford spectacles must now go on with the pair of spectacles you have got, and you others who are coming up to the presbyopic stage, you are in employment and you can afford them anyway." That is what one would be doing in going after a section of the Health Service like that. It is a totally different exercise from any you would have in the United States.

THE ALLOCATION OF RESOURCES IN A NATIONAL HEALTH SERVICE

DR. MILO D. LEAVITT: Today, Sir George is going to talk to us about The Allocation of Resources in a National Health Service.

SIR GEORGE GODBER: I was just discussing with Donald Pitcairn the fact that one cannot start off by thinking: "Now we have got so much to spend on health, we will do this and this and this . . ." When one has an organized health service there is a long list of things being done already, and they are being done in ways to which people have become habituated, and one can change those things only gradually, over time. So one cannot suddenly say, "We have been spending X millions on inpatient care of people who have had hernias because we have been keeping them in 9 days. As from Monday, we will keep them in for 7 days." There will be a surgeon in the backwoods who will promptly keep his in for 10 instead of the 9 days. Things cannot be changed abruptly.

So really, existing services in the clinical field just have to continue. They can be modified and adjustments in what sums are paid can be made in various ways, slowly. One could, for instance, suddenly decide that in the Health Service spectacles would not be provided anymore, and one could abolish that piece of the Service on, say, a couple of months' notice, so that those already in the pipeline could go through. This would really be a saving for the public purse, although everybody who used to get his spectacles that way would then have to pay at least as much for them himself—one wouldn't really have reduced the cost of health care. If there were, perhaps, a number of impoverished old ladies who wanted aids to vision in order to be able to thread their needles and sew, and now were no longer able to, what that would cost in other ways I would not like to think.

Or it could be decided that chiropody services were not justifiable, and a lot of old people who now manage still to totter around, provided that their feet are looked after, would shortly be in bed and using up hospital beds for very much longer periods. Or it could be decided not to have a dental service, which really would mean that a decision is made that people will pay for their own. In that case, one would not reduce the cost of health care unless people stopped having dental care. Or it could be decided not to provide hearing aids.

Now, in the British National Health Service each of these proposals has at some time been looked at, and each time Ministers have decided that they could not be carried out. But they have gone part-way. Charges are made for spectacles, for instance, and the charges are roughly equal to the cost, the real cost of spectacles without a substantial profit margin for the optometrist. That means simply that a contribution has been exacted for that piece of equipment. Then one can use a deterrent charge, which can be termed as either a deterrent or as a means of off-loading part of the cost. For instance, we make a small prescription charge but we provide for exemption for antiques like myself. In fact, my wife and I get our prescriptions free, and children get their prescriptions free. Rather more than one-half of the people get their prescribed drugs free because of the exemptions that have to be made for those who

might be caused excessive hardship by having to pay. I don't mean that my wife and I would be, but a lot of people who are no longer earning would be put to considerable hardship if they did have to pay for drugs; and they are more likely to need drugs than younger people.

One could make charges for dentistry. We do make charges for dental treatment, and those charges can be loaded by imposing heavier charges for dentures than for conservative treatment. This, of course, is to move dental practice away from extractions and the provision of expensive dentures and toward conservation. Though in the end this may cost more in any given year, overall it is likely to cost less.

Similarly, a charge for an appliance could be made, surgical shoes, for instance. Someone who is wearing a surgical boot with an appliance doesn't have to buy an ordinary boot. So it is not unreasonable to make a charge such as the person not needing a special boot would have to pay for ordinary footwear. The same could be done for surgical belts, on the general thesis that everybody has to wear a belt, I suppose, although that may not really be so.

Provisions have always to be made for children, for old people, and for those who are destitute. In fact, 47 percent of all dental care in the Health Service is free, and rather more than one-half of the prescriptions. Then one can modify practice by a gradual rundown of some part of the service, for instance, sanatoria for the tuberculous. They, in fact, ran down much too slowly, because as ever there was a vested interest in keeping them going, even though it might be only someone's salary that was related to the number of beds actually in use. Still, over time, an adjustment of that kind can be made.

Then there can be a change in method. For instance, one can use acute psychiatric units in general hospitals and day hospitals. But it takes years to adjust psychiatric practice, and often it requires capital expenditure to provide a new unit at the general hospital. We have been moving steadily through that particular picture so that now we use for psychiatry just over two beds per thousand of the population, instead of 3.4 as we were using 20 years ago.

Some hospitals can actually be closed and sold, for instance infectious disease hospitals, such as those that we had covering the whole country 25 years ago. All the small ones have long since been disposed of or put to some other use.

Again, cash assistance can be suspended. For instance, at the beginning of the Service we used to pay traveling costs for patients. Within about 2 years, as a means of saving expenditure, that was stopped. But there is an arrangement to help the destitute to get to hospital, under the Social Security system. Then, increase can occur, and this will occur naturally by the general drift toward more sophistication of medical practice. There will be more complicated, more scientific methods, using more expensive new drugs, and so on.

Again, quite suddenly it may be decided to generalize a new development such as hemodialysis for renal failure. Extra money has to be found to attempt that kind of treatment for end-stage renal failure, as no doubt is appreciated in the United States. We did not go quite as far as you did. The introduction of poliomyelitis immunization had an offsetting gain in the reduction of expenditure for the treatment of poliomyelitis. Immunization against rubella has an offsetting long-term gain in that there will be fewer children born with congenital handicaps who will need care for a long time.

In another direction, one can be taken with the story about cervical cytology and believe that morbidity and mortality from cervical cancer can be reduced and a pretty expensive undertaking can be set up such as we have covering the whole of Britain. That can be limited by deciding to undertake it only for women over the age of 35 or who have had three or more children, which is what we have done to prevent cervical smears being taken from everybody and requiring the payment of additional fees for so doing.

It is possible to include a service as part of the Health Service, and perhaps pay extra fees for it. The present British Government decided it would provide free contraceptive drugs and appliances to everyone who wished to have them, and would also provide, under the National Health Service, for the sterilization of people on other than strictly medical grounds. That has been a recent bargain with the profession involving additional fees to gynecologists, anesthetists and to general surgeons for doing vasectomies in men.

One could also decide to abolish a payment that is already being made such as the prescription charge. The Labour Government in 1965 did abolish the prescription charge and within 2 years had to eat their words and put it back again. It is really a kind of tax, but it does also have some deterrent effect. Now, in Brazil they provide prescriptions free, and I believe you will find, in many houses of the poorest group of people, many preseriptions that have never been dispensed. Prescriptions are free, but the drugs are not, and the patient keeps the prescription as a memento of the consultation, and does not get the treatment.

Government could decide to develop an entirely new service, which the Health Service is going to pay for, such as the development of postgraduate medical education between 1962 and the present (paid for through the National Health Service). Or nurse training could be reorganized and expenditure increased in that way.

Central advocacy can be used for particular priorities, like giving better care for those with mental handicaps, either in hospital or by setting up special training centers for mentally-handicapped children still at home. Or it can be demanded that patients in geriatric accommodations be better fed, or that long-stay patients should generally have more spent on their food—these things have been done.

Until today, every year under the Health Service, there has been a percentage increase for revenue expenditure in real terms of the order of perhaps 3 percent or more, and by encouraging the use of that increment in particular ways, one can influence the way in which the Health Service develops. It is only by using that or by using money from economies that authorities are going to get any kind of development in the Health Service.

The main influence on revenue costs in a health service is through manpower and remuneration. Broadly, manpower in the hospitals in Britain has increased by a factor of at least two. The number of nurses has increased by a factor of 2.25. The number of doctors in hospital has increased by a factor of 2.25. But in general practice the increase has been only by a factor of about 1.15. In the other professions, such as the medical laboratory technicians, they have increased by a factor of up to 3. Manpower in family practice has increased a good deal less, but one does not get as fair a count by simply counting the number of general practitioners. The ancillaries add up to having increased by a great deal more, and manpower in the support services

such as home nursing and public health nursing has increased still more. Home nursing, for instance, increased by as much as 37 percent in the last 8 years, and the other nurses have more than doubled since 1948.

A hospital breakdown of expenditure for the year 1972-1973, which is the last one I have with me, shows that salaries and wages amounted to 69 percent of the revenue costs in hospital; and drugs, supplies of blood for transfusion, food and services added up to another 18 percent. Building maintenance added up to another 3 percent, and the central administration to only 3 percent.

So, it will be seen that there really isn't nearly as much room for maneuver in the other things as there is in manpower. The depression of salaries for many of the people employed in hospital–not the doctors (except the juniors), but nurses, technicians, and domestic staff–kept the costs of staffing hospitals abnormally low. The increase in the cost of the Health Service in the last complete year in real terms was 9 percent, but 8 percent of that went on bringing the lower salaries up to what might be regarded as a reasonable level. In comparison, for instance, with the established senior doctors, it is a good deal lower than can be found in, say, any of the Scandinavian countries.

So, anyone faced with the problem of sharply reducing revenue expenditure is almost certain to do it by delaying recruitment of staff, or actually cutting staff or capital work. In a National Health Service, delayed recruitment of fully-trained professionals means unemployment for those professionals, because there is no other work for them to do in the country. There is virtually no other employer. That could be a reason for some of the migration of doctors to Canada and Australia and, to a lesser extent, to the United States.

The changes in proportion of expenditure in the last 15 years have been due largely to growth in the hospital portion. Hospital revenue expenditure, at the beginning, was about 54 percent of the total expenditure on health, and it has now become 58 percent. Hospital capital was 3 percent of the total health expenditure, and has become 8 percent–so those two items have meant a 7 percent increase in the share of the hospitals in the total allocation.

General medical expenditure as a proportion of the whole was 9.5 percent; it is now only 7.6 percent. The general pharmaceutical service has remained at roughly 10 percent throughout; that is, drugs prescribed in general practice. Doctors order for their patients in general practice a one-third greater proportion of the money available to the Health Service than is spent by that Health Service on their own remuneration.

The general dental service was 6.6 percent of the total, and has fallen to 4.7 percent. The provision of spectacles uses just under 1 percent. There are some hidden factors in this, such as the local authority nurses joining in with the general practitioners and therefore subsidizing primary care, because their salaries count against something else.

Salaries were a 3 percent higher proportion in the hospital revenue expenditure in the last complete year. The hospital's capital was a deliberate addition made around about 1960, after a long period of insufficiency in capital development. Most of our public investment in capital projects was on schools, housing, and the redevelopment of industry just after World War II, and there was very little left over, even for necessary maintenance expenditure on hospitals. So, around 1960 we made our first serious essay to increase the expenditure upon new hospital building, and that had grown until it had become 8 percent of the total Health Service expenditure in 1974.

The cost per inpatient day has increased by 3.7 times, but the cost per case treated has increased by only 2.6 times, since the Health Service began. That is, incidentally, not in constant prices terms.

Hospital drugs and dressings have been in roughly the same proportion throughout, and medical equipment has increased from roughly 3.5 percent to 4.75 percent.

The allocation between different aspects of the service to patients in primary care or general practice is really only possible by choice made by the practitioner himself, and acceptance by the patient. The medical practitioner can be influenced by information provided by the medical journals, or centrally, on the costs of drugs. He can be influenced by a financial inducement to undertake a particular form of treatment such as immunization, or he can be influenced in the opposite sense by the risk of incurring a penalty, for instance, for over-prescribing.

The postgraduate medical education organization can be used to promote the most economical use of drugs. I do not mean just by using cheap drugs, but using drugs to the best advantage. It may be better to use a more expensive drug for a short time than the less effective, less expensive drug for a much longer time with less certainty of a cure or improvement for the patient. That educational source of information is independent of service considerations. The service comes in separately by visits of doctors from the central department to discuss their prescribing with those doctors who order much more than the ordinary expenditure in drugs. The *Prescribers' Journal*, produced by an independent committee but paid for by the health department, is a publication circulated to all general practitioners every 2 months; its purpose is purely educational, and its policy is controlled entirely by the expert committee which currently is under the chairmanship of a general practitioner, but has usually been under the chairmanship of a distinguished internist or clinical pharmacologist.

The general practitioners can be influenced in the direction of public policy by the paying of extra fees, as I have described, for preventive work such as immunization and cervical cytology. Better facilities can be provided for general practitioners in under-doctored areas in health centers, or an additional basic practice allowance can be paid to tempt physicians to go into an under-doctored area.

There can be penalties for excessive prescribing, but mostly we have relied on visits. As mentioned in an earlier session, one man was costing £9,000 a year for tetracycline which he was prescribing for topical application to varicose ulcers. He had to be deterred from that by being heavily fined by withholding of his income.

In general dental practice, fees for service have been quite deliberately slanted, as I described, toward conservative treatment rather than extraction. In immunization, which is arranged through the area health authorities, implementation can be stressed, and payments for this are accepted as proper charges on the funds areas have from the department. In the days when those funds came from local taxation, implementation could be kept within the limits that authorities thought they could afford.

Funds can be allocated to different aspects of hospital care by dint of exhortation from the central departments. For instance, Kenneth Robinson and later Richard Crossman, and then again Keith Joseph, all made a strong

point about doing more for those patients in long-term care. They are, in effect, living out their lives in hospital accommodation, and therefore are deserving of rather more attention to their social needs than perhaps the patient who is going to stay only a week. I have mentioned the stress that was laid on food for patients in long-stay care as part of an attempt to improve their general social maintenance.

The campaign for improved postgraduate medical education was done entirely on the basis of exhortation to hospital authorities.

There have been numerous administrative exercises of staff training, particularly for hospital administrators in the earlier days, ranging down to schemes for incentives for cleaning staff to do their work more economically and expeditiously. There have been drives to improve the control of infection in hospitals, with the secondary object of reducing the overall average length of stay. And, one can advocate facilities for managing special groups like patients with epilepsy.

The central department can offer a particular allocation for projects for improving the care of geriatric patients—which was done by Mr. Robinson. Allocations can be made for providing special wards for the mentally handicapped, which was done by Mr. Richard Crossman, or for the funds made available for intermittent hemodialysis which, again, was accomplished by Mr. Kenneth Robinson.

A small amount of money out of the total, never more than about $2 million, could be reserved for the support of small projects for clinical research, monitored entirely by the central department, handed out on the recommendation of regional research committees. Other funds were used centrally for research and development.

Voluntary funds can be used to get certain developments going, as when the Nuffield Provincial Hospitals Trust largely financed the first 2 years of postgraduate medical education, and later financed the first 5 years of the central Council for Postgraduate Medical Education before this was taken over by the central funds of the National Health Service.

The King Edward Hospital Fund for London set up a college for training hospital administrators, and got the specific training for that discipline off the ground in the very early days of the Health Service. They also set up residential colleges for training in nursing administration, and for training in hospital catering. They subsequently passed all that on to the Health Service, but if they had not shown the way, it is unlikely that the Health Service would have gotten off the ground nearly so quickly.

Sir Keith Joseph did one thing which was quite exceptional. He managed through his own contacts with private charities to collect funds sufficient to establish eight additional chairs in specialties that badly needed developing. They were chairs in general practice, in geriatrics, and in rehabilitation. That meant that he had tapped private sources for something like £2 million of endowment for those particular chairs in the space of a couple of years.

Then, most important in the Health Service, there can be deliberate allocations of capital. When first we had money allotted by the treasury for a capital development program, we were highly selective. We asked regions to suggest some of the most urgent large schemes which they were unable to tackle on their regular allocation, and we selected something like a dozen projects which, in the early 1950's, cost £250,000 or more, each. That may not

seem like a very large amount, but it was large in comparison with the size of schemes started previously. Then, as more money became available, we went on to the point of selecting actual new hospitals to be started. The 1962 program, mentioned in previous talks, was to be financed by a progressively increasing capital application to be spent on major schemes chosen for their urgency. As the program grew larger, the regional allocations were stabilized, and the regions were left to choose their own major programs with the department only deciding which should start when, in order to spread out the total of capital expenditure for the hospitals.

The rate of development was very heavily influenced by the varying capacities of the individual hospital regions. There were three regions which, in the early days, were more efficient than others in getting major building done. When those that were less efficient found themselves not in a position to spend their capital within the year, the efficient ones, being by nature predators, were ready to snap up any capital that another region could not spend within the allotted time and add it to their own spending. Oxford, Newcastle and Wessex, for instance, made a good thing out of that in the early days.

I explain that the money must be spent in the individual financial year and cannot be carried over, even for 1 year, once it has been allocated. Of course, when capital developments occur, there is a consequential increase in the revenue allocation required for that particular region. In the hospital service this has been one of the most important ways of getting additional money to places where it was needed. For example, Wales was probably worse off for hospital building than any other part of Great Britain, and it was deliberately given a larger allocation of the capital resources pro rata to population when we first had a capital program. The result is that the expenditure per head on health service in Wales is now greater than the average for England and Wales. Scotland was given its capital program earlier than England or Wales, and that has been a factor, though not by any means the whole of the story, in the much greater amount of money available to Scotland for the health service there.

Before the National Health Service, the distribution of resources was grossly unequal. It depended to a large extent on the revenue available from local taxation, and from charitable sources, and was more plentiful in the southeast of England than in the Midlands and the northwest or the northeast. So the health services were, on the whole, better in the south and southeast than they were further north.

The early development of specialist staffs filled the gaps particularly in the north, and that did produce some adjustment in the financial allocation, because staffing is so large a part of the attachment of resources. It did not by any means produce the levelling off that was needed, because it was much easier to get staff in the south of England than further north, and if they could not get senior staff, they could more commonly attract British-born junior staff. So one found, as time went by, that more foreign medical graduates were coming in, and that the proportion in the north was very much greater than in the south. We did not restrict the numbers of doctors overall; we restricted only the number of consultants, and then the senior training grades. So they just filled up with senior house officers and house officers.

I have mentioned the way that capital distribution went; and I add that, in addition to Wales, areas that were more or less destitute, like West Cumberland,

or had been badly damaged in the war, like Hull and Coventry, or places like Truro or Huddersfield or Poole, which had bad existing hospitals, got the first development.

The capitation system in general practice helped to level things off a bit, but not enough, because often the towns where the ratio of population to general practitioners was greatest were unsalubrious areas, and doctors (perhaps doctors' wives and families more than doctors) were unready to go and practice in them. For example, Barnsley or Rochdale were unattractive to people who didn't happen to come from that part of the world. But it did help, and to this was added an inducement payment to general practitioners who would set up in specified under-doctored areas. For local health authority services, there was a substantial differential in the central government rate support grant, which met roughly 50 percent of the cost of local authority-provided services. That 50 percent would be reduced to 40 percent in the well-to-do area and increased to perhaps 60 percent in the area with the least local resources in proportion to need.

An analysis published in *The Lancet* in March 1974 contrasts Health Service revenue expenditure in the different regions; and one finds that areas like the North Midlands, the West Midlands, and East Anglia were then getting only about three-fourths of the sums that the best-treated areas (mainly the London metropolitan areas and Liverpool) had to spend. Rudolph Klein, in a recent publication, shows that there are even greater differences between areas within those regions. One of the present Ministers has been making the point that regional comparisons do not deal with the situation adequately, in themselves. The point that Noyce and Snaith make in their paper is that where there is a hospital shortage it has not been made good by other services in the community. In fact, where one is short of one kind of service, one is likely to be short of another. That does not apply in Scotland, however, where the hospital services have always been better developed than the community care services, and on the whole there is much more inpatient treatment in Scotland than in England and Wales.

Mr. Richard Crossman, when he was Secretary of State 4 or 5 years ago, devised a program for a progressive adjustment to take account of population and age distribution within the population and morbidity. It was a very complicated formula and it was to lead to adjustment by selective use of increments in money available to the Health Service as a whole. It did not get very far, but it did make a slow beginning.

Of course, some of the increases in costs of the Health Service are quite unpredictable. If there is an influenza epidemic it is more than likely to put anything up to £10 million to the drug bill in general practice, and that is one of the areas in the service which is not controllable, because the drugs have been used before they are paid for, and government can't say, "Very well, we spent our allocation of drugs by mid-February. There will be no more drugs until the first of April when the new financial year begins." So they just have to make it up, as they have hitherto, by supplementary allocations (usually, a small amount of money is held back to look after that).

That leaves us, really, with manpower control in the hospitals, both medical and nursing. That has been applied consistently on medical staffing throughout, and it is applied by regions on hospital nursing staff. Although there are theoretical establishments for nurses for all hospitals, in fact nearly all of them

go short. If they have not enough money in the kitty for meeting the necessary nursing salaries, that means that the nurses who were to be recruited within the financial year will not be recruited at the same rate. In that way, of course, the services do go short.

There are much-publicized proposals for adjusting what will clearly be a decreasingly sufficient allocation of funds for the Health Service between potential users. There is not enough for the British Health Service at the present time. There has never been as much as could have been effectively used. In some ways, it may almost be that the system has been too efficient in containing the costs, mainly because of the role of general practice. General practice will fill in the gap left by the failure of the hospital service to do all that it set out to do. (At least, it covers up the defects left by people having to wait too long for hospital care.)

Ordinarily, there could be choice of the use of increments to be effected locally by, say, a division of surgery deciding that it is not going to try and develop a particularly expensive form of surgical treatment, but instead it will use its available funds for doing what it is doing already rather better. Or, within medicine, it can be decided that they will not have within their resources the capacity to set up a unit for specialized gastroenterology, or for end-stage renal failure. In the district management team that sort of decision may be spread over other services within the hospitals of the group, and there may have to be a reduction in the use of perhaps some particularly expensive drugs. Economy will be used selectively on method, not by withdrawal of ordinary care from some group.

The area health authority, which has to try and reconcile the budgets of the different districts, is advised by its own medical advisory committee and it may have to say to the individual district, "You won't be able to have money for that particular development this year unless you can find it by an economy." The regional health authority, in its turn, monitoring the area health authority and also advised by its own medical advisory committee drawn from the different areas, may have to say the same sort of thing and decide not to develop this or that specialist team until additional funds become available.

That sort of decision has to be made in sequence, starting with the district attempt to envisage the budget it will get; then with the area's plan for the services in its own area; then the region's plan for the region as a whole. All that will be done in consultation with the liaison team from the Department of Health and Social Security with some knowledge of the funds likely to be available from central sources for the next financial year. In reaching the assessment of what the department can get from the Treasury, and the way in which what it does get is to be used, the department's own policy groups (who plan for particular kinds of specialized development) advise within the department. That advice goes down the line—not as an order—and determines the way in which allocations to the regions, the areas and the districts may be modified.

Manpower control in medicine, at any rate, will be exercised more directly in consultation with representatives from the profession. A region will be told that it can have only so many additional consultants in the course of the next financial year. It will be told that it will have only so many senior registrar posts for advanced specialty training.

Rudolph Klein, in *Inflation and Priorities*, discusses the guidance that was given to regional health authorities in December, 1974. I have not been able to get a copy of this myself, so I believe that Rudolph must have gotten it from some regional health authority's papers. The guidance that regions were given on priorities was that the objective would be to maintain the increase in the medical school intake; to develop capital facilities for primary care (that is health centers); to maintain the level of capital expenditure for long-term care, which is the most expensive form per capita of medical care, to reduce waiting lists; to fill gaps in existing provision; to raise the level in deprived areas, and to complete capital works already in progress to a functioning level. Rudolph Klein is highly critical of all of this, and he emphasizes that it is suggesting support for development in the least controllable sector, which is primary care. There, the money is spent before the department really has any say in it. In fact, I suspect that in the cold, hard light of today, that list of priorities is going to get rather scant attention from the regional health authorities this year.

The present Minister of State, David Owen, gave an interview to the *Sunday Times* about 2 weeks ago, and he envisaged returning to the sort of priority selection in the capital field that we were doing in the 1950's in the period of extreme shortage. He talked about emphasizing the population component in deciding where the money can go. But this cannot be on purely a population basis; because Liverpool, for instance, has expensive hospital care partly because its hospitals are old and bad, apart from the very few that have been built under the National Health Service. It would be a great deal better, of course, if we had been able to achieve a satisfactory capital building program during the 1950's. We didn't get off the ground on any scale until well into the 1960's, and so we are still having to make do with a lot of extremely inefficient buildings.

What I have tried to do is to set out for you a somewhat different version of what allocation of resources has to mean when you have an established health service. You cannot think up where you would like to allocate the resources and then say let it be so. You have something that is running now, and it has to go on running. You can only change its direction, but you *can* convince local people and get them to make these essential adjustments locally. You are certainly not going to be popular with the electorate if they suddenly find that you have cut off the money necessary to maintain a substantial chunk of the service in a particular area for the last 3 months of the year. I believe that just will not happen, and the politicians will find themselves forced to adjust to that need.

You could, at the beginning, say that we are not going to finance this or that. It would have been possible in 1948 to have said, "We will not finance dental care." It would have been possible to have said, "We won't provide spectacles." It would still be possible to declare that we will give up providing hearing aids—if there weren't about 500,000 voters who had hearing aids at the moment—and I believe it will not be so declared.

Therefore, one is left with what Mr. Enoch Powell described as the problem of steering Leviathan. He said that the National Health Service was like Leviathan, and he meant that one could only deflect it in subtle ways over the long term. One could not put a bridle on it and persuade it abruptly to change course. I believe that is the position of any organized service. One can decide to

go in different directions at the beginning, though they would only be directions compatible with the kind of service already provided. After that, adjustments can be made by providing extra funds and allocating them to particular aspects of the service, or by persuading people to modify existing services.

We are not going to have another dividend like that of the antibiotics in the 1950's, which gave a concealed increase in the resources available to the Health Service, so that we got a lot of changes of direction without the British Treasury being even aware that there was money they had not been able to get their hands on. They were, fortunately, unsophisticated.

This may be highly heretical in a country that believes in planning the way you do, but I still believe it to be a fact of life.

DR. MILO D. LEAVITT: Are there any questions of Sir George?

DR. GORDON HATCHER: On what basis were decisions made initially, either in the National Health Service or in the prior emergency medical service or hospital service, as to how many specialists of a given kind you needed in a given region?

SIR GEORGE GODBER: There really wasn't a decision made. Under the emergency medical services, one was patching in order to provide what one could in a wartime situation to meet an acknowledged shortage. There was a great shortage. There was a series of recommendations produced by a group of senior specialists at the Ministry of Health, as it was in those days, before the Health Service. Their recommendations about the development of consultant services were not precisely quantified, but set out rather the principles of development in different specialties, and the order of staffing that might be needed in a hypothetical district or region. Those were used not as exact guidelines as to how many staff were needed, but as general guidelines regarding the kind of spread of specialties that would be needed. They were generally pretty well accepted, and regions applied them according to their own lights. But regions had been allocated so much money, and they could afford only a number of additional specialists or other doctors within that total sum of money. Therefore, they started down the same road; they went down it at different paces, according to the amount of money they had available. Some of them, like the Newcastle region and the Northwest Metropolitan region and the Oxford region, jumped in, realizing that this was an opportunity to get their hands on what staff they could while the money was still available. They got off more quickly than other people did. After that, a sort of rationing system had to be introduced, otherwise the southeast of England would have picked up all the people in the shortage specialties such as anesthesiology and psychiatry. That rationing system was used simply to allot the available number of posts that it was likely to be possible to fill—in, say, anesthesiology—to the areas where the need for them was greatest.

So one might get in a year applications for 100 different consultant anesthetists, and know that there were only likely to be 50 suitable people. One then had to say arbitrarily, "These 50 get the priority." Then one would turn around and try to increase the number of training posts in that specialty,

so as to be able to meet a large number of applications in subsequent years. That is the way it was done.

DR. HATCHER: Does that mean that at the present time you might have twice as many pediatricians per thousand population in one region than in another? Or three times as many orthopedic surgeons and so forth?

SIR GEORGE GODBER: I don't think there would be differences as wide as that. There would be differences of the order, perhaps, of four to three, as between some of the regions. There would be a concentration of specialists around the teaching hospitals, because of the teaching and research responsibilities there. When one gets outside to the nonteaching centers, then the staffing at different centers will not be widely differing, because this rationing system has been operating. There were regions that were notably parsimonious and did not ask for more staff. The defect in the system was that it was a rationing system. It didn't say, "You will have so many." It said, "You can't have more." If someone said we want 10 psychiatrists in the coming year, and one knew that there were not more than 3 or 4 to be had, one said, "You may have three or four out of your 10, come around next year for some of the balance." There are still quite substantial differences between regions.

MS. KATHRYN ARNOW: You talked about the long-term general drift to a more sophisticated practice. At the same time, well, not at the same time but somewhat later, you said that it was possible at the district level or the surgical command, so to speak, to decide that they were not going to adopt a more expensive practice in the wings. How long can one hold off against new types of practices when they are already, say, in the research hospitals, or being widely used in another country and in the literature?

SIR GEORGE GODBER: One of the surgical procedures that has been pretty widely used in the United States is coronary bypass surgery. I think we can hold off that as a routine for a long time.

MS. ARNOW: I have heard that the Dutch are trying that, too, and that they claim that the Americans are substituting it for changing their way of life. It just happens that you hit the example I got when I put the same question to someone else.

SIR GEORGE GODBER: It is difficult. For instance, you have done quite a lot of heart transplants in the United States, though I know you won't be doing many more. I believe you have only two surgeons doing active heart transplanting now. In Britain we have had three heart transplants done altogether. I got the experts in this field together and they advised and agreed to a letter which I sent out nearly 3 years ago, saying that at that time we were not justified in diverting extra resources to heart transplanting. We would continue immunological and other research and wait and see how the research workers in other countries, meaning this one, got on with it. Somebody subsequently leaked this to the press. Later, a surgeon did a heart transplant and the public and medical press reacted badly to it. It was really quite interesting. But that is, of course, an extreme example. This was not direction

but guidance through consensus on lines broadly supported by the professions and the public.

I think the decision will usually be in a different branch. It is the sort of thing, well, my wife knows more about it that I do, because it happened in a group in which she was a member of the management committee. One of the surgeons started to do herniorraphies on a 2-day stay and then return by ambulance home, and after-care at home. That was being done by a relatively few people in Britain at the time. There were two other general surgeons, one of whom took it up. The third at first did not, but eventually he had the example of his colleagues' waiting lists rapidly going down and he decided to adopt the same methods. There is short-stay surgery of that kind, or outpatient surgery, which a surgical division could adopt as a policy in suitable cases, in order to conserve resources for other kinds of work for which there are waiting lists.

MS. ARNOW: So the quality of review of a new procedure and the view of the cost benefits, just to use our expression, takes place really very close to the actual practice.

SIR GEORGE GODBER: Insofar as it is done, but it is not done enough, in my judgment. It is not done systematically enough, with sufficient detailed information. It has been part of the troubles of the last couple of years, the disaffection between doctors and management, perhaps, that the move toward closer examination of work in this way has been interrupted. It really isn't simply an economy measure; it is much more important as a measure of the effectiveness of therapy. People are apt to think only in terms of saving doctors' or other professionals' time in a hospital, and forget how much of patients' time gets wasted. I believe that the monitoring of results is far more important as a means of securing the quality of patient care, and a reduction in the wastage of patient time, than the reduction in the wastage of professional time, about which professionals usually tend to be thinking.

UNIDENTIFIED SPEAKER: I think my question is a little along the same line. We are scared to death of national health insurance in the medical practice in this country, and I ask whether, in Britain, national health insurance is discussed reasonably rationally, and do you think that decisions are reasonably rationally made?

SIR GEORGE GODBER: Well, we are a moderate lot. (Laughter) I believe on the whole that the decisions that are made are sensible decisions. But I do not believe that effort is deliberately directed toward the best sort of outcome, as much as it should be. I believe that the individualistic training of medicine still too much conditions what people do. I do believe that the introduction of the divisional system, or what is called the Cogwheel system in British hospitals, has led to a more practical decision about the best application of the resources available.

UNIDENTIFIED SPEAKER: I was thinking more of the general discussion, though, not within the medical profession itself, but in the general public.

SIR GEORGE GODBER: Discussion about the Health Service?

UNIDENTIFIED SPEAKER: Yes.

SIR GEORGE GODBER: I believe that one of the troubles about public discussion of the Health Service is that too many people still start with a sort of neon sign in their subconscious that we have the best health service in the world. I don't happen to believe that. I think we have a good workaday service, as good as anyone else has. If I am caught short, as it were, in my medical care, I would rather that it was in Britain than anywhere else. But I do not believe that comment on the Health Service among the public is generally as well-informed as it might be. I believe that a deliberate attempt to inform them fully has not been made, although there is much more understanding of what we are trying to do than there used to be. I think that membership of hospital management committees and local health authorities and that sort of body (now it is area health authorities) means that the public does feel that it is still in control of its own Health Service. It does not believe that it is simply exposed to whatever the government or the profession sees fit to inflict on it.

Now, the best advice on this is sitting at the back of the room. My wife should say whether that is a fair comment, if she heard.

LADY GODBER: Yes, I think that is true. I believe the people who are in hospital and so forth are much more concerned with what is happening to their own local selves, what is going on in their own medical place, than with what is going on out in the British Medical Association or anywhere else.

SIR GEORGE GODBER: I believe that in spite of all the headlines being made at the present time, the Health Service, when you get out into the field, is really going on as satisfactorily as it was a year or so ago. The posturing and attitudinizing that the politicans and the leading doctors are indulging in cuts no ice with the general public at all.

UNIDENTIFIED SPEAKER: But you have really answered my two questions in the opposite way. The discussion is bad, the service is good.

SIR GEORGE GODBER: No, what I meant on the first point is that I do not think that the public is informed in depth about the sort of issues I have been discussing this afternoon. I believe that it feels generally that it is getting a pretty good level of service. I was talking to one of your colleagues just before I came in here, and he told me two stories, both about the ambulance service, which he and his family encountered in Britain this summer. The story of the person who collapsed in a London underground rail station with a coronary and was picked up by the ambulance within about 3 minutes and taken to hospital; with no argument about where he would go or whether he would be admitted because there would be a known hospital to which he should be taken. The other account was also about someone who collapsed, but it happened to be just outside a pub, and the ambulance was there within minutes, again. So was a policeman, who leaned down and said, "Have you been drinking?" The man recovered enough to sit up, put up his hand and say, "Guilty as charged." (Laughter)

Now, he didn't go to the hospital, but the point was that the Health Service operated to bring the health resource to him immediately.

I believe that the Health Service, to most people, is their own family doctor. Senator Edward Kennedy, when he came to Britain, made a point wherever he went of asking the people he encountered (not professionals) who was their family doctor and what sort of a chap was he. He was a bit taken aback to find that they all knew and could all make the comment. So it works, all right. In my answer, I meant the sophisticated understanding of the detail, and discussion of the detail that the kind of service provided. That may be a factor in your excessive litigation about malpractice; it may not be there in Britain, because I think it is being looked after.

UNIDENTIFIED SPEAKER. Does Britain still have much use of the home as a site of delivery for maternity services, or do they pretty much handle that in the hospitals?

SIR GEORGE GODBER: No, not a great deal. About 94 percent of deliveries now take place in hospital. Ten years ago that proportion was probably under 70 percent. The change has been very rapid in the last decade, although this is one of the things that one Minister recently wanted to put into reverse. Maybe he believed that women ought to have labor pains, and I think he mainly thought that it would be cheaper. Such investigations as we have made suggest that there is not really a great deal of difference in the cost in our Service. In any case, the unquestioned advantage in morbidity and mortality to both mother and infant, which is demonstrated by British statistics in considerable detail, would not, I believe, permit any Minister to backtrack on that.

PROFESSIONAL AUTONOMY, PRIVATE PRACTICE AND THE NATIONAL HEALTH SERVICE

DR. MILO D. LEAVITT: Sir George is going to talk to us this afternoon about Professional Autonomy, Private Practice and the National Health Service.

SIR GEORGE GODBER: In Britain, the National Health Service employs directly or contracts with around 60,000 doctors. That is more than 90 percent of the total of economically active physicians. Just over one-half of them are working in hospitals, and of that half, about five-sixths are employed full time. But about three-fifths of the hospital doctors are junior and in pupillage and, therefore, their clinical activities are under the direction of other members of the profession, who are responsible for their training. About 25,000 doctors are in general practice.

Doctors in general practice are not employed on a salaried basis; they are independent contractors. They have contracted to provide certain services, at their own discretion as to the content of those services. They are subject to terms and conditions of service, which broadly indicate that they are responsible for seeing that any patient registered with them receives any care that he or she needs, either directly from the doctor, if it is within his competence, or by reference to a specialist, if it is something that should be in the hands of a hospital specialist. So, the general practitioner is the portal of entry to the whole Service.

Payment is made by a rather complex method, but one-third to one-half of it is included within a basic practice allowance. At the beginning of the Service, the doctors were very anxious not to lose independence, as they thought they would if they became salaried officers. They were not prepared to consider even a part-salaried, part-capitation basis of remuneration. That is why it is termed a basic practice allowance, but it is barely distinguishable from a part-time salary. However, the proprieties are preserved. The balance comprises capitation and some fees for work under the heading of "in accordance with public policy." This does not mean that practitioners are told they must do this or that; it means that they are given incentives to undertake some work which is not part of the ordinary treatment of patients, including preventive activities like immunization or cervical cytology. And if they do that work at their own choice, within the limits set by public policy recommendations coming from the center, then they are paid an extra fee-per-service for it. This is quite a small part of the total remuneration.

There is also a small group of physicians engaged in preventive clinical work, exemplified by the School Health Service. They are, as they were long before the National Health Service, salaried doctors. There is a group of physicians, also salaried, engaged in medical administrative work. There are others not employed in the Health Service, but employed by the military, industry, Medical Research Council or by the universities, and they are either salaried or working on grants from the Medical Research Council. Nobody has ever considered salary paid by a university as enslavement.

The whole National Health Service scheme is predicated on the justification for obtaining treatment being medical need. It is assumed that services that are needed will be made available, so far as they are practicable in Britain. If a service can be provided for the benefit of one person, then any other person with the same need ought to be able to get it.

There is no payment at the time of use, except for certain kinds of supplies. For example, drugs prescribed for patients who are not inpatients of hospitals are provided only after the payment of a relatively small sum, a great deal less than the price of most drugs. For some other appliances, like dentures, for instance, the sum, which is perhaps one-half the cost, is paid by the patient. As mentioned in our last session, there are charges for appliances that are akin to garments, such as surgical boots that may be worn with certain orthopedic appliances. If those boots were not worn, the patient would be having to buy normal boots, therefore, he pays a sum toward the cost of those boots or other things akin to garments, such as surgical belts.

For spectacles, what amounts to almost the production cost of lenses and frames of a simple kind is paid by the patient. However, the patient can pay for frames of his choosing, and optometrists have a way of producing new kinds of frames that may be thought to make the wearer more attractive. These frames do not readily get into the schedule of frames available under the National Health Service, but a good standard type is provided. There is no charge for artificial limbs or hearing aids. There also are means for meeting the charges, where charges are made, for people in need through the Social Security system. Additional sums can be made available from the Social Security side of the Health Department to meet, for instance, charges for appliances, if the patient is unable to pay the small amount involved. This is such a blanket provision that 47 percent of all dental treatment is free. I should also have mentioned there is a modest charge for each course of dental treatment for adults, and that this charge covers a full course, even if the full course amounts to a very extensive conservation program. Dental treatment provided to children, expectant mothers and old people is free.

Sixty percent of the drugs prescribed in general practice are dispensed free because of the eligibility of the recipients.

Use of these services is optional, but there is no grant in aid of private care. It is a breach of the terms of service for a doctor who is in general practice under the National Health Service, and who has accepted a patient on his list as one of those for whom he will care, to take any fee for National Health Service treatment from that patient. There are some things he can do. He can, for instance, sign patients' forms for getting passports or international certificates. Now, that is not medical care, but he signs them because doctors in Britain are considered to be reputable people who can be relied upon to sign that people are who they claim to be. Until a change made a year or so ago, the doctor could receive a fee for providing a prescription for an oral contraceptive to a woman seeking to obtain those preparations on social rather than strictly medical grounds.

A public patient in general practice can be a private patient of a consultant. I recently went to see a consultant. My general practitioner could have referred me to that consultant as a private patient, had he chosen—had I been prepared to be treated outside the National Health Service. I was going to my GP as a National Health Service patient, but I did not wish to go outside the NHS, and

people seldom do. However, there are occasions when, for instance, a parent of a child who the general practitioner thinks might need a tonsillectomy, knowing that there is a fairly long waiting period and intending to take the child away, shall we say for summer vacation, and wanting to get the job done before that happens, may ask the general practitioner to refer him to a consultant privately.

A private patient of a general practitioner can be a public patient of a consultant. Someone who is not on the general practitioners' list can be sent to a hospital outpatient department for consultation in exactly the same way as a public patient would be. A private patient cannot be prescribed drugs under the Health Service. The profession has always argued that this privilege should be available to them, and there have been Ministers who have arrived in office inclined to effect this, but have changed their minds on examining the implications of such a change. A change would introduce great complications about the checking of prescribing.

Probably 97 to 98 percent of the population have registered with a general practitioner, and they have made their own choice of general practitioner. It is true that if you are a newborn baby, you do not have much choice, but your parents can be held to be competent to make the choice for you. Otherwise, one makes his own choice—unless one simply says to the Executive Council, "I do not mind your putting me on the nearest man's list." And if he is prepared to take you, then you go on that list. But change is possible and if a disagreement occurs between patient and doctor, as may well happen, the patient can say to the doctor, "I want to go to another doctor," and he is entitled to say, "Well, I do not think you should." However, the patient may still say, "Nevertheless, I will, and I give you notice of my intention to change, and 1 month from this date, I shall ask the Executive Council to change my registration over to another doctor." The general practitioner might suddenly take a dislike to you and say, "I have decided that I do not want you or your family on my list any more. You were (shall we say) grossly abusive to my wife when you telephoned in my absence yesterday, and you can take your business elsewhere." He then has to give 1 month's notice, but he can divest himself of that patient. There are in any community a very few people that nobody would want to have on his list; the usual gentlemen's agreement among doctors is that everybody takes his turn with such patients. The doctor exasperated with behavior over a long time, unnecessary calls and that sort of thing from a particular family will say, "Now, look, you have been with me for 2 years and that is all I can take. One month from now, I shall ask the Executive Council to take you off my list, and I suggest you go to one of the other doctors in the town."

UNIDENTIFIED SPEAKER: Do patients' records follow them as they move around?

SIR GEORGE GODBER: Yes, records are transferred from doctor to doctor. They are not the property of the doctor who made them. They are attached to the patient, but are not given to the patient. They are passed to the next doctor through the Executive Council.

A total of 2.2 percent of all hospital inpatients in 1974, for which I have figures, were private. But, only 1.1 percent of the beds were beds for paying

patients. They are specifically designated for use by paying patients and they usually are different only in certain amenities. They are usually 1-bed or 2-bed rooms, and most beds, even in the new wards in Health Service Hospitals, are in 4-bed bays. There will be a sufficient number of single beds for use by those needing them on medical grounds.

Most paying patients are those suffering from acute illness. There are, of course, some pay beds in hospitals for the mentally ill, and even a few in geriatric departments. But the great majority of them are for patients who would otherwise be in the general wards.

There are two large insurance schemes with a total premium income in the last year, for which I have figures, of £36 million. That is rather less than 1 percent of the cost of the National Health Service in that same year. They paid out about three-fourths of that in benefits to patients; I am in no position to tell you how much goes into the administrative costs of these schemes. I am not suggesting that these costs would amount to the remaining one-fourth, but I guess that the percentage is a good deal more than the 3 percent which was the administrative fraction of total National Health Service expenditure.

Fees for paying patients in pay beds originally were controlled, but they are controlled no longer because of pressure by the profession—which said that it was quite wrong that anybody should attempt to classify operations as minor, intermediate, or major. We had, in fact, included such a classification in regulations made right at the beginning of the Service, and doctors got more and more indignant about it and pressed us to know how we had made this particular listing, which we though was out-of-date, and which we were ready to alter with their agreement. The existing list was, in fact, based on the list drawn up by the profession for use by one of the major private insurance agencies. After all, there are such lists in the United States. This episode reflects the rather resistant attitude the profession takes to anything surrounding private practice.

There is complete clinical freedom in general practice. The contract is to provide service, and that service is not subject to approval or report. General dental practice is paid by item of service and is subject to approval for major estimates, and to report after inspection by a departmental dental officer on a small percentage of patients. General medical practitioners are paid by capitation, not by fee per service. And that really is the difference. In effect, one is telling a doctor that he will get a basic practice allowance for running a satisfactory general practice in the Health Service. It will be larger if he is in group practice; larger, if on entry he has had approved training before entry into general practice; and the allowance will be subject to seniority additions after longer service. For the rest, he is given so much per head of those on his list, and he is expected to provide what they need. It is up to him to see that the service is up to the level of his patients' needs.

Doctors are free to prescribe any drug, and they do so. They get showered with advice from the drug firms, about the benefits of providing particular proprietary preparations. They get a much lighter shower of advice from expert committees of the department and through a journal financed by the department, but run by a professional committee. The department finds the staff of the committee, but the committee consists of members of the profession appointed after consultation with them. The committee runs the journal with any content it pleases. It has been a successful journal of advice on

prescribing methods, usually with a series of short articles on topical subjects. It was so successful that the Swedes for a long time bought it in bulk and circulated it. The Australians also used to buy it.

The prescribing costs of each physician are checked in the course of the paying of the chemists for the prescriptions they dispense. Physicians who prescribe more than 50 percent above the area average per head may be visited by doctors from the department to discuss the reasons why their prescribing may be excessive. Those reasons may be entirely understandable. There are some conditions where very heavy prescribing is inevitable. Let us say, one has two or three incontinent patients on one's list that use large amounts of dressings and substantial amounts of expensive drugs. This may push up the individual's cost unduly. An older doctor may have an older-than-average practice population, and therefore he is more likely to prescribe drugs. Exceptionally, someone whose prescribing continues without apparent justification well above the level of his colleagues in the same area may be taken before the local medical committee (a committee set up by the profession locally) as one who has been prescribing excessively.

There is another aspect to this. A man could prescribe drugs with great freedom simply on the patients' request as a means of attracting patients, and because of this possibility, the doctors themselves were not entirely ill-disposed toward having this sort of check placed on them. In fact, it is not a very onerous business. However, if somebody goes on prescribing at a greatly excessive rate, regardless of representations to him, he may be penalized for prescribing large amounts, especially of expensive drugs, or simply because his total cost in prescribing is much higher than that of other doctors.

I mentioned previously the man who in the course of a year prescribed very large amounts of tetracycline for topical application to varicose ulcers. In another instance, a doctor might prescribe something—one of the high-protein milks, for example—as if it were a drug needed by his patient, who might, in fact, really want it as a food, which it is. If that happened, it would be referred to referees, who would say, "This is a food and not a drug," or alternatively, if it were a different kind of preparation, "This is a cosmetic, and not a drug." The general practitioner would simply be told, "We do not pay for that prescription; you do," which would deter him fairly quickly.

I mentioned some of the preventive activities, among them cervical cytology, for which fees are paid. I picked this one because it shows what is meant by the definition of what is public policy. It was decided to establish a generally available service of cervical cytology for all women 35 years and over. If it had been proposed for all women one might find women under age 35 having smears taken rather than those over 35 who have much greater risk, but might be less willing to undergo the procedure. We were very cognizant of the problem presented by a young married woman of 35 with a positive smear, and nobody really knows what should be done in those circumstances. There are some surgeons who might do a hysterectomy; there are others who would merely say, "No, this is very uncertain. We must repeat this smear every 6 months." That could condemn the girl to a life of uncertainty, unless and until the smear reverted to normal. The policy was subsequently modified to include women under 35, who had had three children. This was on the general basis that the problem is not nearly so difficult with someone who has completed a normal-sized family. Repeat smears can be taken every 5 years—or if the first

smear was unsatisfactory, a repeat can be done at once and paid for in exactly the same way. There is nothing to prevent the general practitioner wanting to take a smear from getting it examined. He would be doing something he was not asked to do as an item of public policy, and he would not be paid extra for it, but he could get the laboratory examination of the smear just as if it were in the public policy group, and many do.

I have gone into that in detail because it shows that fees are an incentive for optional things that government hoped would be done as a preventive program. If there are other things that the physician wants to do, like immunization against influenza, which the department did not want to encourage, there is nothing to stop the physician from doing them. He can get the vaccine free under the Health Service on payment of the prescription charge by the patient and administer it. But the department is not going to pay for that. If the physician thinks it is his duty, he can go ahead. So that does not restrict the practitioner's freedom. It simply does not encourage him to do things which expert groups have advised, as in the case of cytology, should not be generally promoted.

Now, supposing the general practitioner fails to fulfill his terms of service; supposing he is called to see someone at home and does not go, or that patient is seriously ill; and the physician delays a visit. Finally, perhaps, another physician is called later in the day, and the patient goes to hospital and perhaps does not survive, or does survive a very stormy illness. A complaint may be made to the Executive Council by the patient or a relative that the terms and conditions of service were not fulfilled; that is a breach of contract. And for that breach of contract, the physician may have a censure or a withholding of some part of his monthly check. But supposing he did go, and made a mistake, having been reasonably careful, but he made an error of professional judgment. He would not be disciplined for that, if he took reasonable care, but the patient might have grounds for action in the courts in that the doctor had not shown the skills that he should have been expected to show in providing the particular treatment that he did. He can be guilty of malpractice without having been guilty of breach of his terms of service, and then, it is the courts and not the service that will penalize him. But if he fails to fulfill his terms of service to the patient, then the service penalizes him. There is an appeal against this. And the Secretary of State may, in serious cases, appoint three people to conduct the hearing of an appeal, usually a lawyer, a departmental doctor and a doctor nominated by the profession. On their report, he makes a decision. All cases of severe penalty go before a medical advisory committee of which one of the Deputy Chief Medical Officers is chairman, and 3 British Medical Association–nominated doctors and 2 other departmental doctors attend. They usually agree on whether the action taken by the Executive Council was adequate, excessive or inadequate and the penalty can be adjusted accordingly. But again, these are not matters of clinical judgment, and for those, the patient has recourse to the courts.

The right of the patient is to the medical care that he needs. But that does not mean right to immediate attendance, regardless of convenience. The patient who has had pain in the back for 3 weeks and thinks that 9 o'clock on Sunday evening is a good time to get the doctor in because the television program is not very good may not get the doctor—quite naturally. But supposing the patient has, say, symptoms suggestive of an acute surgical

abdominal condition, then that doctor will go to attend him even if it is the middle of the night. He either goes himself or he has provided for a deputy to go. This business of provision of deputies is a matter of concern at the present time. Doctors are entitled to arrange for appropriately qualified deputies to act for them if they are off-duty or away on holiday or sick. These sometimes are provided by commercial deputizing services, and some doctors have tended to write-off their night-time commitment, as it were, by referring much of the emergency work to deputies. Moreover, there may be deputies over whose competence and assiduity the doctor himself has no control. The deputies may also fail to pass on information about the patient, and there is a danger in this to the principle of continuity of care, which is fundamental to British general practice. Then, too, the great majority of doctors now do their consulting work on an appointment basis, instead of having a large waiting space and just announcing certain hours within which they will see patients and all other comers. That, again, can become an obstacle to consultation at the right time, and there is reason for reviewing such arrangements.

Regarding consultants. The consultant is appointed by a regional hospital board or hospital authority on the recommendation of a professional advisory appointments committee. The advisory appointments committee normally has a non-medical chairman, usually a person experienced in this sort of work, and it has a specified constitution, including medical and non-medical nominees of the management committee or the health authority of the area in which the doctor is going to work, nominees of his future colleagues and one independent nominee from outside the region—from a list provided by the appropriate Royal College and the nominee of the relevant university. Thus, one has an almost entirely professional committee which makes a selection on good professional grounds, and is not excessively exposed to local nepotism. It makes an assessment of perhaps half a dozen people after interview, and will recommend Drs. A, B, and C, in that order, as qualified for the post advertised. It would not provide more than three names.

The regional board, almost invariably, takes the first recommendation. I can recall one instance when they did not, and took the third recommendation. The reason was that, although the hospital concerned was set up by women and staffed by women, a predominantly male advisory appointments committee had chosen to put the most suitable woman applicant for the post third on the list. There was not much doubt that this was unjust as well as unwise of the advisory appointments committee. As a matter of fact, the chairman of the board talked to me about it beforehand, and I told him what his rights were. The board exercised its right and took the third choice.

The appointee to a consultant job then accepts the commitment to do certain things, to give all his working time, or, perhaps, nine-elevenths of his working time, to looking after an appropriate section of the work done in his specialty in his hospital involving, shall we say, charge of patients in particular beds or consultative outpatient sessions—there will always be both in the clinical specialties—and perhaps, operating sessions, if he is in one of the surgical specialties. If he is in a laboratory specialty, he accepts responsibility, shall we say, for the clinical biochemical work of a district laboratory. He then works as he chooses. He has responsibility; he has junior staff and support, and he is responsible for organizing their work. He can be cited by the employing

authority for failure to perform his duty or for negligent performance of his duty, but not for the clinical choices that he makes.

To go back to cervical cytology, the gynecologist who chooses in a particular case to do a hysterectomy where it may be customary or have been customary to treat such patients by radiotherapy in that particular department will not stand to be questioned by the employing authority for making that choice. Of course, if he makes an inexpert choice, he may be challenged by the patient, who may think she has suffered because the doctor did not show appropriate attention to her case. But in the last 10 years we have been developing within our hospitals a divisional system under which there will be, say, a division of surgery in a hospital which can review the work done by the whole group, and the resources available to it, and try and achieve the most rational use of those resources. It also tries to share among the surgeons the help given by the junior staff and to share appropriately among them access to operating theaters and outpatient time.

Supposing a particular surgeon asks the hospital authority to obtain a particularly expensive appliance, or even to use an especially expensive brand of a particular drug, he may be told by his division that, in the light of the resources available, it cannot be afforded. His professional colleagues will make the recommendation although the final decision is the responsibility of either the medical executive committee made up from the divisions (if it has delegated responsibility), or by the authority itself.

Of course, what doctors choose to do has to fit in with the nursing organization. It is, for example, no use cardiologists' deciding that they will organize a coronary care unit, if the nursing organization is unable to meet the nursing requirements of such a unit. In this regard, there is not as close cooperation as there ought to be.

If a doctor is consistently failing to carry out his work successfully, or if, say, he is an anesthetist and is believed to be sniffing his own drugs (one of the hazards of anesthesiology), then the hospital authority could inquire into the facts and decide to dismiss him. The first case I remember of that kind was a radiotherapist, who tried to insert radium needles into the tongue of a patient—the physician was said to have had too much to drink. It was alleged that there had been other similar incidents and his employing authority decided to terminate his contract. Any such dismissal is subject to appeal to a committee which has to be chaired by the Chief Medical Officer of the department, which consists normally of two representatives of the profession and two people from the department, one of them usually a consultant-advisor in the specialty in question. Appeals are not by any means always successful. I recall one case in which a teaching hospital wanted to dismiss an orthodontist who had declined to carry out treatment in accordance with what he had been told to do by the senior orthodontist, who had no power to direct his clinical activities in that way. The hospital board of governors was angry because it was told that that was the man's clinical freedom, which should not have been imposed upon. I recall another case where a medical superintendent of a mental hospital (who was a very good psychiatrist and had done a great deal of good work in the hospital) was said to have become autocratic and overbearing to a degree that made it impossible for his colleagues to work with him. His contract was terminated by the hospital authority; his case was considered on appeal, and the decision confirmed.

Guidance on clinical policy may be given on the authority of a professional advisory body from the center. The very first one I recall was guidance about the kind of apparatus that should be held available in the hospital service for dealing with respiratory failure in poliomyelitis. It was just after the Copenhagen outbreak, when positive-pressure, artificial respiration through a tracheostomy was widely used. Instructions were not issued, but everybody knew that the tank respirators that we had at that time were less successful than others, and hospital authorities were enabled to have the new apparatus available. But that was done on professional advice.

Then perhaps the clearest example of prescription which has been generally adopted is in the immunization schedule. We pay general practitioners extra for any of the immunizations in that schedule, but not if they do some other immunization. That schedule was drawn up by an expert committee including general practitioners, consultants, neurologists, bacteriologists, and epidemiologists, chaired by Sir Charles Stuart Harris, who is a world authority on this subject. There has never been any real challenge to that advice, and practically everyone follows it.

Again, advice was formulated by our standing advisory committee on the prevention of hemolytic disease of the newborn. And steps were taken to obtain anti-D-globulin for general use in the prevention of rhesus sensitization. Advice was given to pediatricians, other hospital staff and general practitioners about selection for operative intervention on the newborn with myelomeningocele. That advice was drawn up by an expert group, after a large conference had been held and endorsed by the standing medical advisory committee. This was distributed to all doctors concerned, and neonatal mortality from spina bifida did increase within 3 months of the advice being disseminated. This was not a question of anybody being given a direction, but in a very difficult field, the issues were examined and guidelines were suggested for people to use if they chose.

A clearer example, perhaps, was the recommendation of an expert group about transplantation of the human heart which I mentioned earlier. The expert group included all the leading people interested in doing this sort of work. There was general agreement that what had been done was right.

I remember a particular example of an ambulatory method of treating varicose veins which was fairly widely adopted. The department had financed a special study, which was published and showed that the technique was an economical one, and was as effective as the surgical methods then being used. It did not issue any kind of directive.

We have tried to handle the difficult problem of tonsillectomy, but we can never obtain clear professional advice about it. The Medical Research Council has not yet succeeded in devising a controlled clinical study, although a limited one was done with the support of the Nuffield Provincial Hospitals Trust. No clear advice has been issued on tonsillectomy, but we came nearer to giving a direction over this, than anything else, because there were at one time some otologists who were refusing to allow parents to visit their children immediately after tonsillectomy. The department did not issue a direction over that even, but all hospital authorities were told that the standing medical advisory committee had endorsed the strongest kind of advice that visiting should be permitted. That advice was also communicated to the chairmen of

the hospital medical committees in a letter from the Chief Medical Officer, but no order was given.

Now, as to private practice—Mr. Bevan, who was the Minister who introduced the National Health Service, was, of course, a Labour Member of Parliament with a very progressive approach, he was a deeply interested man. His party was opposed to pay beds, but there were pay beds in the voluntary hospitals that were being taken over—a small number of them. They had been established not for wealthy patients, but for patients not sufficiently well-to-do to afford admission to such small private hospitals as existed before the Health Service came in. In the end, Mr. Bevan came to the conclusion that he would get better cooperation from the consultants if he allowed a small number of pay beds to be used—and as I have told you, this is only about 1 percent of the total. The consultants who were doing private work would then do much of it inside the hospitals and not be so much away from the hospital practice which ought to be the major part of their work. He made that concession in spite of opposition within his own party—and he had to carry it in open argument in Parliament. He also made a concession about general practitioners in health centers, that they should be allowed to undertake a limited amount of private practice.

At the beginning we had limits to the fees that could be charged in pay beds. These were subsequently removed because a later Minister, who was a lawyer, had doubts as to whether it was legal to prescribe them. They had then been running for 17 years without anybody challenging the legality in the courts. In any case, the profession was always asking Ministers to remove the charge limitations. There was undoubtedly occasional misuse of this privilege of private practice. There were good, young doctors who knew of occasional cases in which their seniors had absented themselves from their proper hospital work in order to deal with private cases. It was a common jibe that the first case on any consultant's operating list, if there were pay beds in the hospital, would be whatever paying patient he happened to have in at that time. It was always believed that in the radiological department, the private patients got in first. I have no doubt that such abuses did sometimes occur. Whenever they were reported reliably, they aroused great resentment, perhaps more among the nurses, other lower paid hospital staff, and among some junior doctors, than in the public. Abuse was certainly believed to be more widely prevalent than I think it actually was. The best consultants, indeed the majority of consultants, took great care not to abuse the principle of equality of access to needed care, but it certainly was often easier to get admission to pay beds for non-urgent surgical intervention. That was not necessarily misuse, but it was a source of discontent, and is the sort of thing to which the Labour Party, now in power again, understandably takes the strongest exception. It is a point which could perfectly easily have been met by saying there will be a common waiting list, all patients will be admitted in order of medical need, and the private patient will take whatever turn is appropriate on that ground—and when his or her turn comes, will be admitted to a private bed. I have met young doctors who have so strongly disapproved of this sort of thing that, for instance, a senior registrar, himself quite near reaching the consultant grade, on being asked by his consultant if he would keep an eye on a patient in one of the pay beds while the consultant was away for the weekend, said, "No, I do not approve of private practice in hospital. You will have to get one of your

colleagues to do that." I believe that to be a perfectly understandable attitude in the circumstances. The story was told me by the consultant concerned as evidence of disaffection among junior staff. I think it is evidence of a different kind of principle, adherence to a perfectly valid principle.

I had better explain that I have never had a fee from a patient. I ended up an office doctor because I was determined from the time before I was qualified that I never would. You will see that I am clearly on the side of the whole-time consultant, which I should have been had I qualified 10 years later. But that does not mean I would favor coercing others.

I mentioned that 85 percent of the consultants in Scotland are whole-time; against 48 percent of the consultants in England. The grievance is concentrated, therefore, among rather less than one-half of the consultant body, and principally, among only a minority of them. I will say bluntly that I believe the current dispute has been mishandled on both sides. I think the tail has been wagging the dog in that the interests of the minority of people with substantial amounts of private practice have driven the rest of the profession in this dispute, and that they have sometimes been indiscreet in what they have said and what they have demanded.

I am bound to say that the Minister has behaved provocatively toward the doctors in the circumstances, but there are a lot of other staff who would have resented anything less on her part. Now, she, the Minister, is a politician. It is for her to decide how provocative or not she should be and to whom. Nevertheless, the combination of these two factors, along with other problems, has produced the worst dispute that our Service has ever had. It could not have come at a worse moment, because the worst feature in the Health Service at the present time is lack of money to develop it for the non-fee-paying patients.

It is not universally believed that the reduction of private practice is really a threat to freedom. Many general practitioners have chosen not to do any at all. They do not feel that their freedom has been reduced, neither do the Scottish consultants seem to feel that way. I do know that some very well-motivated consultants, and some of them young, have felt that this is only symptomatic of an invasion of the proper freedoms of the profession. I do not include among freedoms of the profession (and nor do they) the right to exploit patients for whatever the traffic will bear. I do not mean that sort of attitude at all. I believe that it is probably the way in which the attack has been made that has antagonized some people like that. I mention that there are other consultants holding the sort of view that I do about practicing privately, who might well take the opposite view to that, and feel that it is purely mercenary that the profession should take the line it does. My belief is that the middle way is really the answer.

This is a conflict of personalities, perhaps ill-advised, of people having temperaments unsuited to the purpose in hand.

Well, that is as far as I go this afternoon.

DR. MILO D. LEAVITT: Are there any questions for Sir George?

DR. CLIFFORD MALONEY: I think I have waited a suitable period for more appropriate questions. I think the last suggestion centers on why we in the United States are so afraid of centralized government—I do not want to suggest anything about the British experience—but the issue is, the issue I am

raising, is to what extent the rights of the people in the Service, not the patients, not the public, and the practitioners have been specifically attended to if it is to avoid abuse. In particular, I do not believe that the right of appeal means a lot because there is a tremendous tendency for appeal boards to back up what was said at the earlier stage. Or do you not think so?

SIR GEORGE GODBER: I do not think so. I chaired the appeal on consultant dismissals for 13 years, and there were not very many, perhaps a dozen or so. Because of the length of the period, I certainly chaired more appeals than anybody else has done, and I am sure that everyone had a fair crack of the whip. I recall the case of one particular consultant, whose appointment was terminated, because all the general practitioners asked that it should be terminated. They would not trust their patients to his care. The situation was examined exhaustively. If a consultant has completely lost the trust of his colleagues, who have been sending him patients in our system (he would not get them in any other way), then he cannot be permitted to continue in the position in a relatively small district. To do so would deny those patients surgical attention from someone else who would be acceptable professionally to his colleagues. The man was looked after and put into another post at a sub-consultant level, he was not turned out into the cold. From my experience of the handling of this sort of thing I would say that it erred in the other direction; I could have found—anyone who really knew the people involved could have found—many more people who might, for the public good, have been removed from their jobs.

DR. MALONEY: In all facets of life, we have this difficulty. Centralization puts power in people's hands, and there is a great deal of attention to seeing to it that the people subject to the power behave, but is there enough attention given to see that the people with the power behave?

SIR GEORGE GODBER: I think that the Health Service is rightly hedged around with all sorts of safeguards against that. The result has been that too little severity has been shown on occasion, and that too great a freedom has sometimes been allowed to some of the people involved. I chaired for some years the committee that considered serious cases against general practitioners, some of whose remuneration had been suggested should be withheld. I was very conscious of the fact that the general practitioners' colleagues, who were three out of the six forming the committee, always looked at these cases on the basis of, "Could that have been me; could I have done something like that?" And if they felt that way, they would recommend more tolerant treatment of him. And I would always take the same view in such cases. Again, I would say that the benefit of the doubt always went to the man concerned in such a thing, which amounts, after all, to just withholding of money. There is a defect in this in that there is no way in which the doctor can complain about the patient. Some patients are totally unreasonable. But possibly they are totally unreasonable on what could be pathological grounds of a psychological nature. Power can be misused, yes; but if one has no power at all, the situation can be abused in the most extreme way by the professionals concerned.

I am not making any judgments about this. I am only repeating something that was on the radio news last week: seven doctors in the District of Columbia

had sums exceeding $100,000 paid to them under Medicare/Medicaid last year. I do not even know if that is true. All I will say is that I do not believe that there is any doctor whose professional work of any kind is worth $100,000 in a year. You might say that I am just an egalitarian. All right, that is still my belief.

DR. GORDON HATCHER: A point on the question of centralization which is more of a concern, I think, than decentralization. For the first 25 years of the Health Service, it was decentralized in how many different ways? How many local executive councils were there? How many regional boards?

SIR GEORGE GODBER: There were about 140 executive councils and 14 regional boards, plus Wales. These covered England and Wales.

DR. HATCHER: Did each of them have multiple nominations of professional and non-professional members?

SIR GEORGE GODBER: Yes.

DR. HATCHER: So, in a sense, it is a highly decentralized administration, I think, without parallel. I want to ask you a question that perhaps you can answer: What steps are being taken or are likely to be taken as a result of the present crisis?

SIR GEORGE GODBER: A Royal Commission has been set up. I only know this from the press, of course. If you want to read an exercise in intemperate commentary, you will have to read *The Times'* report of the House of Commons debate just after this announcement, and you can take your pick between the sides. It is a toss-up, as far as I am concerned. I believe that the Royal Commission, if it looks seriously at the problems of the Health Service, cannot fail to say to the government of the day that the most grievous problem of the Health Service is its underfunding over many years. It had virtually no major capital development during the 1950's. The amount of capital provided for building a new system of hospitals had since that time to be developed. But today, with the Health Service having just reached the point of spending £250 million annually on hospital building, it is going to be cut back drastically, as it must be in Britain's present financial situation.

I am not quibbling about that, but I am sure that the Royal Commission is certain to say, loud and clear, that the main problems of the Health Service arise from underfunding. I think it is going to be precluded from dealing with the question of private practice and pay beds; the argument being that such is really not a National Health Service matter anyway.

I believe the Commission may have some comments on the reorganization, and there is an anomaly in the reorganization. It was necessary to fit in with political realities about elected local government, and that meant having an area tier in the hierarchy region, area, district or losing the other two. So that instead of having only region and district, one has to have the area because there are certain functions to be discharged there. If there were a regional level of government for other purposes as there may soon be in Scotland, it would be a different situation. So, I feel that there will probably be recommendations

about that. This government has at most another 4 years to run. British governments do not usually run their full term, but it has at most another 4 years.

The Royal Commission, the chairman of which is not yet appointed, can hardly get down to work seriously until next year. It has a very complicated subject to unravel. Royal Commissions hardly ever take as little as 2 years, and I believe this one is likely to take 3.

If, then, there is a report published at the end of 1978, or say early in 1979, it will be close to the end of the life of this government. There would have to be discussion, and then legislation, if there were to be changes. A major administrative change would be positively damaging now. Legislation would certainly be highly controversial, and not likely to be a convenient plank for the next election. I cannot see how it could be, because the existence of the National Health Service is common ground to the parties. I do not believe that we are going to see a result from this Royal Commission in terms of any modification of the Health Service, should it so recommend, that requires legislation, earlier than the second year of the government after this. Now, I am doing political guessing, and I am not a politician, and I could be wildly wrong.

DR. HATCHER: Will private practice continue until that time on the same basis?

SIR GEORGE GODBER: I do not think so. I believe that this government is committed to action on hospital pay beds. I am not really surprised that it is committed to it, and it is my belief that pay beds will probably be phased out during that time. I don't mean that private practice will be prohibited. I think much has been made of the possible regulation of private practice. It is most likely to be regulation in terms of quality of facilities to be allowed to be used, because there is already regulation of the quality of establishments run as nursing homes or private hospitals (not nursing homes in quite the American sense). Thus, if we are looking for an outcome as a result of the Commission's deliberations, I think it will be sometime in the 1980's. This is the guess of an amateur politician.

HEALTH MANPOWER POLICIES, REGULATIONS AND REQUIREMENTS

DR. MILO D. LEAVITT: I am delighted that you are able to join us this afternoon for Sir George's last presentation, which is on Health Manpower Policies, Regulations and Requirements. Without further ado, I turn the chair over to Sir George Godber.

SIR GEORGE GODBER: For an awful moment, David, I thought you were going to say, "We are delighted that this is at last coming to an end." If you did not say that, I could understand if you thought it.

We have a case history of health manpower happenings in the National Health Service. Looking back at the Service's early stages it is difficult to describe the manpower situation as a coordinated policy. I think we realized relatively late that we had to have a policy about manpower in the Health Service, because it is one of the most highly labor-intensive services possible.

In the hospital section of the National Health Service, nearly 70 percent of the revenue expenditure goes on salaries and wages, probably more now that all lower-paid staff have received salary increases.

In general practice, two-thirds of the payment to general practitioners is for remuneration, about one-third for expenses. But part of that, a large part, goes for the payment of ancillary staff, so again, the major part of the expenditure is on manpower.

In preventive work, most of the expenditure is probably on medical and nursing salaries and salaries of supporting staff. And so, hiring policy in the National Health Service really largely determines its total cost. If there are to be substantial alterations in the running costs of the National Health Service, these will be accomplished by employing more or less people.

The increase in National Health Service costs in 20 years in real terms has been 141 percent. The increase in manpower has been well in excess of 100 percent, but salaries, particularly for the lower-paid group, in recent years have been substantially improved. Nursing salaries have gone up, I believe, a total of 60 percent in the last 3 years; I dealt with the breakdown on this during our eighth discussion so I will not go into further detail on actual costs.

Our first attempt at manpower control came quite early, and was related simply to hospital doctors. One of the things that happened as soon as the Health Service began was that the under-staffed hospitals—which were most of those outside of the large centers and teaching hospitals—had a marked increase in the amount of medical manpower available to them. The consultant grade particularly increased in the first year or so. Then, since they were operating within a fairly tight budget, some of the hospital boards began to increase their staffs much more in the junior grades, particularly the senior registrar, the advanced specialty-training grade. And that was what first brought us up against the problem that we had far too many doctors in advanced training grades for specialties, without places in the consultant grade to which they could go.

The first intervention was to have a review of all hospital medical staffing in each region by two senior consultants from a different region. They would go around each region to reach conclusions about the kind of staff required. (This was a good example of the futility of entering into this sort of exercise without any kind of guideline.) The consultants were given no plan; they were just sent out to look to see whether regions had enough staff or too many or whatever, and they came back from the 14 regions with 14 different answers based on 14 different sets of standards—or not based on standards at all, more commonly, just on guesswork. The main thing that emerged from this was that there were wide divergencies between regions. The Newcastle region and the Northwest Metropolitan region, for example, tried to apply rational standards of staffing.

There had been an earlier essay (before the Health Service began) at suggesting how the consultant services might be developed. Figures associated with those recommendations were theoretical, but had some rational basis and were related to populations. They would have required, over time, something like doubling the existing consultant staff. This seemed very large, and precise calculations based on those estimates were very much played down. In fact, within about 15 years, they turned out to be very near the true position, though not, I think, near the full needs as we would see them now.

There were differences in the vigor with which regions tackled their needs and differences in the allocation of funds. Funds had been allocated on the basis of what regions had already, with percentage increases, a method apt to "give most to him that hath and least to him that hath not." There was some attempt at leveling up, but the numbers of staff available and the relationship of additional staffing to additional funds made available were not at all well-coordinated. The process, therefore, was very gradual. Most of the established specialties, such as internal medicine and general surgery, had been staffed up; so the shortages were in other specialties.

In order to try to keep control on the growth in the consultant grade, a joint committee with the profession was established, but all it could do was to review applications from the regions for additional consultants.

The appointment of additional consultants was conditional on central approval on the advice of this joint committee, which contained about 6 people representative of the profession, all outside senior consultants, and only 3 persons from within the department and 2 of their outside advisors. The committee continued to operate until succeeded by a somewhat similar committee of a different name about 3 years ago. As far as I know, it did not at any time vote on any decision; it always managed to reach conclusions by consensus; but what it was doing was only deciding on applications for additions to staff. Since people were mainly trying to fill up shortage specialties, such as anesthesiology, this resulted in rationing the distribution. In anesthesiology, shall we say, only 50 additional appointments might be allowed in a year, because it was calculated that in the year that was all the people we would have trained fit for consultant appointments.

So it was not really manpower planning, and the committee was not able to go to a region and say, "You have asked for 1 anesthesiologist, but your need is clearly greater than other regions', and you ought to have asked for 4 or 5, which we would have given you in preference to giving a couple each to some of these other regions which have better staffing standards."

There was also a firm limit on the senior registrar grade, which meant that we had controlled entry to the last 4 years of specialty training. However, that did not mean that we would not be faced with a lot of full-trained senior registrars with no consultant posts open to them—this simply meant that we had put the point of entry a bit further back. People knew that if they once became senior registrars, they were virtually certain to become consultants, so they just milled around doing additional 2-year registrar posts, in the hope of getting into the senior registrar channel. Many of them could not succeed.

The profession itself indulges in a curious sort of double think on all this. It upbraids the department for not increasing consultant establishments centrally, but peripherally. It says (too often), "Well, of course, everyone else ought to have additional consultant staff, but we can manage in this district if we have a couple of extra registrars to help us." That, I believe, was the principal obstacle to the rational growth of the consultant grade, and to the rational distribution of doctors in hospitals between the training grades and the consultant grades. We still have a disproportion in spite of all the central efforts, by exhortation, to get additional consultants appointed. We still have an absurd ratio of about 1.4 juniors to 1 senior, which means that it is quite impossible for the people in training posts, in, say, surgery or internal medicine, to anticipate that more than a fraction of them will ever get through to the consultant grade.

This is one of the main reasons for the dissatisfaction among young doctors in Britain, and for the number of them who have emigrated. Because if someone is trained onward and encouraged to get additional qualifications up to a certain level, and then he is told, "Sorry, chum, but you can try general practice," he does not take kindly to it. By this time, the doctor is probably in his middle thirties, is married, has a couple of children, and really has the need to get himself established in a post for which he is trained. The chances for a woman at the same level may be even worse. And general practice requires its own kind of training, not the training appropriate to, for example, a general surgeon.

Of course, one cannot direct people to the right kind of training post. One cannot say, "Everybody whose name begins with 'A' down to everybody whose name begins with 'DE' will be a psychiatrist"—it is no use attempting to train people in specialties for which they have no vocation. Because the pecking order in public esteem in the medical profession is still neurologists, neurosurgeons and cardiac surgeons at the top, internal medicine next, and people like psychiatrists and geriatricians a long way down; the younger doctors are not encouraged to aspire to advanced training in the kind of specialties in which, if they do have any inclination, they could be most useful and most certain of getting established.

Radiologists and radiotherapists seem to have provided one of our greatest difficulties; they have tended to move off to employment overseas. I believe that radiology is one of the more profitable specialties in North America; it most certainly seems to have attracted many of our specialists in the field.

In the last 10 years we have, in Britain, tried to develop much more effective career guidance, so that people will try to get training in the right specialties. We have endeavored to limit the number of junior posts in those specialties which we felt were overcrowded with juniors, and we have tried to persuade surgeons and specialists in internal medicine, and the like, to recognize that a short period at the registrar level with them may be useful

preparation for general practice, but 2 years is not. Slowly, we have overcome part of the problem.

Recruitment to medical schools during World War II and just after reached a peak intake of about 2,500 a year, which was really more than British schools were equipped to carry. As soon as the schools had dealt with the immediate postwar rush, the intake was slowly reduced.

Early in the Health Service, doctors were not readily getting into employment and this was not only into the consultant grade. For various other reasons, it was for a time quite difficult to get established in general practice, so the schools were reducing their intake. There was a feeling in the profession that the intake was still too high, and the British Medical Association approached the health department with a view to having an inquiry into what the intake ought to be. An inquiry was set up by a committee under the chairmanship of the head of one of the Cambridge colleges, who previously had been Minister of Health, to estimate requirements. That was just at the moment when the birthrate was at its lowest, and before immigration had begun. The old population forecasts were inaccurate, as was proved 10 years later, by several millions. Thus the estimates given of the need for doctors were far too low. The committee had also to operate on a piece of rather superficial guesswork as to what the requirements might be.

The slowness of absorption into general practice was in part due to some financial factors surrounding general practice, some of which I have already discussed. But the recommendation of the committee was that the intake to the medical schools should be further reduced to 1,760 a year. That had a nice, spurious precision about it. In 1956, it had the effect of seriously reducing the intake over 4 crucial years up to 1960, because by 1960 the 1,760 figure was still official guidance. Behind the scenes, though, schools had some encouragement to increase their intake. Since then, the intake has increased (following considerable expenditure and enlargement of schools and the establishment of three new schools on the advice of a Royal Commission) to something like 3,600—and it is to go up to 4,100.

However, the problem of hospital medical staffing was not being solved by the increasing intake. This was because the junior posts were increasing and not the senior established posts. Consequently, a new working party was set up jointly—six people from the profession and six people suggested by the departments—to review hospital staffing structure. It was only then that we became aware of the extent of medical immigration. Various persons' pronouncements had been dismissed as being those of scaremongers for suggesting that we might have 1,000-1,500 Indian, Pakistani and other foreign medical graduates among the junior staff in our H[redacted]tals. When we did a head-count in 1960 we found that we had 3,600. That crept up on us because we had not kept a precise record of where people came from. We merely had a head-count of the staff.

Because of the general terms of the recommendations of this working party—about the need for reviewing hospital staffs—a review was again undertaken in each region. This time it was based on rather firmer guidelines, and it produced recommendations for increases (which were not exactly in line for each region because a different team was used for each, but which could be rationalized). We could simply take the median figure for staffing levels and start to bring those regions below the median up to median level, with the hope

of making further increases later. As usual, Scotland was able to get off the ground more quickly, and had the money to pay for additional staff. Scotland went the whole way, increasing consultant staff in their hospitals by 25 percent in a few years, while England and Wales still struggled along behind.

This was the first serious attempt at having a rational calculation of the medical staff needed for any purpose. At about that time also, we had the move toward improving postgraduate medical education, which I have mentioned on previous occasions. It was clearly going to be necessary to review some of our provisions for medical education, especially the London medical schools, which then were preponderantly hospital-based and not in all cases well linked with the rest of the university. The best situation of British medical schools educationally is at present (and has been for a good many years) at provincial universities. This is generally recognized outside London medical circles.

The Todd Royal Commission, set up in 1966, was to review the needs of hospital medical education. We asked them as a first step to calculate what our requirements for doctors were. The Commission had much fuller statistical material about doctors than could be given to the previous committee, and it made an estimate of requirements for medical students upon which the 3,600 and 4,100 intake figures are based. I cannot claim that the Commission's method was wholly defensible because basically it plotted the annual number of doctors in the Health Service and drew a straight line through the points and then extended it. Then it counted out the foreign medical graduates in the total and said, "We obviously must further increase the intake to British schools in order to reach this level." I believe the Commission overestimated what we will require in the more distant future, but I do not mind very much because we will need all the addition that we can get, if we are to provide for staffing the Health Service from our own medical training resources.

Meanwhile, during all this time, doctors have been coming to Britain, mainly from the Indian sub-continent, but also from the eastern Mediterranean; and some doctors have been leaving—usually frustrated people who had hoped to get into one of the specialties—mainly for Canada and Australia. I suspect that both countries will in future be cutting down their intake from Britain. No one is quite sure how many doctors Britain lost, because some went out and some came back. It may well have been of the order of 300 a year, which is nearly 10 percent of Britain's present intake, and a good deal larger proportion of the intake of 15 years ago.

Recruitment to the hospital service, however, has gone on with no central attempt to check it; attempts are made only to channel recruitment into the right grades. Something of the order of 800 to 1,000 additional doctors have been added to hospital medical staff each year of the last 5.

Recruitment to general practice has fluctuated a good deal more, being mainly dependent on the payment structure for general practitioners. During the last 5 years, it has been running at something between 150 and 350 a year; and the number of persons in general practice has been steadily increasing. We tried to attract people to the under-doctored areas by providing them with better facilities, but we did not make as good use of that method as we might have done. Now, with a realistic pay structure for general practice, I expect the numbers in general practice to go on increasing steadily for the foreseeable future.

The influx of foreign medical graduates has distorted the career structure in medicine even more. Most doctors who come from India and Pakistan do not expect to stay, but a proportion of them do stay. Although, again, one cannot give precise numbers (because some doctors born of British parents overseas will be recorded among those born outside the British Isles), it is probable that as large a porportion as 13 or 14 percent of general practitioners in Britain are foreign medical graduates. In the consultant field the proportion is smaller, and may be of the order of 8 percent. Possibly a number of these consultants are from what used to be called the Old Commonwealth or they may be children born of British parents overseas.

The presence of so many foreign medical graduates has had a distorting effect on the thinking of many senior medical staff in hospitals. They expect to be supported by more juniors than a rational system would allow them, and they sometimes show the strongest resistance to adding, say, 1 consultant to an existing total of 4, rather than 1 registrar to an existing total of 3 in a particular district general hospital. It is obvious to anyone looking at the situation rationally that there must be more senior posts if there is to be a reasonable career pattern. It is not fair to say that certain kinds of surgical work, for instance, are fit only to be done by junior grades. In fact, we once had a count in one quite well-developed group, which showed us that one-half of the emergency operating was done by doctors in the rank of registrar or below. That certainly cannot be in the patients' interest, and I believe not in the doctors' interest either.

The hospital authorities, when they are short of money, have an interest in getting more for less, and so they are more likely to look for registrars than for consultants if allowed to do it. That, we have tried to check.

With the present financial difficulties, it will be some time before that situation is put right, but it was slowly moving in the right direction before the present financial difficulties. I believe there also will be further changes in the educational system as a result of the Merrison Report on the control of the medical profession. This recommends the introduction of an indicative specialist registration which will strengthen the claim of the young, qualified specialists to be given more responsibilities when they are ready for them. I believe that in Britain there is now the possibility of effective control of the size and rate of increase of hospital medical staffing. There is an enormous problem from past neglect which has to work through the system before the pattern is right.

We had a problem of insufficient dental graduates, and we had a committee of inquiry in the early 1950's which recommended a considerable increase in places in the schools and much building. We have done much more to improve dental educational levels than we have medical education; admittedly, dental education, at the Health Service's beginning was in worse straits than medical. Today we have an output of dental graduates considered sufficient for our future needs. Entry into the schools has been increased by roughly three-fifths.

The increase in numbers of nursing staff has been 125 percent in 24 years. The increase in registered nurses—fully-trained nurses—is 106 percent. We have another group of nurses who are trained, designated as enrolled nurses, enrolled after a planned 2-year training, which has increased by 200 percent. The increase in student nurses is only about 16 percent from the beginning of the Health Service.

Putting together students for the register and pupils for the enrolled nurse grade, the number of nurses going into training each year has gone up by about 50 percent. We have also made greatly increased use of part-time nurses, especially part-time trained nurses. I believe we are at last beginning to recognize that if the population is in future going to be nursed by trained nurses, then we can no longer rely on the small number of spinster career nurses, and a large number of students, who train and do, perhaps, 1 year's qualified nursing. We have to look to nurses continuing to work in nursing after marriage, and coming back to it, perhaps, in later life. This is happening on a very substantial scale. The upper echelons of nursing have been more realistic than those of medicine.

We are also recruiting more men to nursing. I cannot give you exact figures, but very few men were trained in general nursing 25 years ago; now the proportion being trained is quite substantial. The proportion of them who stay on and eventually achieve senior posts (not because men are better than women but because of the continuity of their presence in the hospitals) is really quite surprising.

We have developed theoretical nursing establishments, which often are greater than anything that is possible and realistic. We have to remember that with nursing students, as with students for the other professions involved in health work and in medicine, we are taking people from the pool that also produces people like school teachers—a pool that is of limited size. Use of the enrolled nurse and training pupils for that level of nursing helps in this, but we still use figures for nurse establishments which are rather unrealistic. They tend to be what people have thought up, and then it is convenient to express the position in terms of being 25 percent short of the establishment. I believe there are but few places which reach the full establishment. The control of nursing establishments is exercised by regional hospital boards, both in terms of numbers and the budget available to them, with the really effective control being by budget.

Rudolph Klein, in his book, *Inflation and Priorities*, makes the point that one of the results of substantially increasing the salaries of nurses in the present situation will be an ability to employ fewer of them. That is something I believe we have not really faced up to, either the people or the government.

There has been some modification in the training of nurses, and some of the special registers, such as that for training in infectious disease, have been closed. But the main change has been the development of enrolled nurse training.

The concentration of our hospital work on district general hospitals or their group equivalents has meant that we now have a smaller number of better-based schools. I believe nurse training to be better now than ever before. We have tried to add emphasis to the status of students in nursing schools, but we do not have university nurse-training schools, as are established in so many places in the United States.

There is some difference of opinion in Britain as to how far it is desirable to provide degree courses for nurses. Personally, I believe that there is a substantial number of good nurses who would relish being able to take university degrees together with their nurse training. But I also believe that a high proportion of recruits would prefer either general nursing, hospital-based or enrolled nurse training (if we do not put the two together, as the Briggs

Committee has suggested) to a straight university course lasting perhaps 4 years. I certainly do not think we would want to move to the sort of situation existing in some South American countries, in which 4- or 5-year university training is insisted upon for all nurses, and no other level of training is acceptable. The result of this stricture is far too few nurses, most of the nursing being done by people with 3 weeks preliminary training, followed by on-the-job learning.

One other small point in relation to nurse recruitment—in Britain we have in some places adopted the practice of allowing girls wanting to go into nursing to join cadet-training schemes in hospitals. These schemes do not place the girls into the ordinary nursing situations, but give them employment within a hospital context.

At this point, I really ought to give my wife an opportunity to put me straight, as I probably have been saying wrong things about nursing. Do you want to?

LADY GODBER: Mainly, I would just like to say about the cadets, that they come at age 16 from school, and 3 out of their 5 days are spent in further education, trying to reach their own level, not in nursing, but in general education. The 2 hospital days are spent not actually giving nursing attendance to patients but in other related work. That is the only point I make.

SIR GEORGE GODBER: Midwives in Britain play a more important part than nurses play in midwifery here. More than 80 percent of the deliveries are done by midwives. Midwifery is a separate training; most entrants to it are nurses who take a further year's training in order to qualify as midwives. They are legally allowed to practice independently, subject to the calling of medical aid, if need be. As nearly all confinements are now taking place in hospitals, they are not on their own, they are in hospitals where the oversight is obstetric, but they play a more independent role within this setting than would be usual for nurses, as I understand it, in the United States.

We have had definition and registration of eight professions supplementary to medicine: radiography, physiotherapy, remedial gymnastics, occupational therapy, chiropody, orthoptics, speech therapy, and laboratory technology. Each of these professions has its own board of registration, and they are grouped together under a coordinating council. The expense of maintaining this registration system is, therefore, spread through the whole group of eight.

Training has been made much more systematic. In some cases, such as, for instance, laboratory technology, much more use is being made of educational establishments outside the hospital in training juniors for the national certificate or the higher national certificate. The higher national certificate is roughly at degree level. Also, in laboratory work, more graduate biochemists have been recruited from the universities.

In all of these professions, the students who are learning on the job are paid, or grants are paid to the students while they are being trained, through educational authorities. Nurses are paid throughout their training, unlike some nurse trainees in the United States. The students do not pay for their tuition, and are paid while they are in the nurse training schools. The other professions have been brought into line with this.

We have not moved as far as we should in providing common content to the training in some of these professions and technologies. In a few places, there is some common content, but we could go a lot further in this, and some of the work in Canada is an object lesson to us.

There are other technologies that have grown up around medicine, and the scientific components of hospital medicine, like physics and electronics and electrophysiology, and there is a group of technicians concerned with the fitting of hearing aids ordered by otologists. Because of our dissatisfaction with the position of some of these technologists, who have been led into narrow areas of work with no opportunity of further progress or training to a higher level with a wider spread of expertise, we had a review of the whole subject about 6 years ago. A committee under Lord Zuckerman's chairmanship reviewed scientific services in hospitals, and made recommendations for the organization of scientific services, including inter alia clinical biochemistry, physics and engineering. These supported the claims of the most senior scientists to be treated on terms of equality with the consultants in the hospital service. Some of our best clinical biochemical laboratories are headed by non-medical biochemists ranking equally with their consultant medical colleagues.

We are grouping these technicians and trying to get them a broader training; for instance, those engaged in looking after various kinds of electronic apparatus and making various kinds of recordings. This is a relatively recent development, but it should improve the position of manpower in those grades.

Overall, the manpower in the professions, other than medicine and nursing, exceeds the total of physicians employed in hospitals. Whereas the doctors have roughly doubled in numbers, these professions and technologies have increased three-and-a-half fold.

The profession of pharmacy is separately controlled. Pharmacists have been legally registered for a long time. They are controlled by the Pharmaceutical Society, whose Council, in the same way as the General Medical Council, has certain government nominees to ensure that the profession's control is not a completely closed shop. There are some university pharmaceutical schools and the provision of senior posts has been encouraged as a result of a recent inquiry into the hospital pharmacy structure. There is now regional planning for the development of pharmaceutical work. Most dispensing in Britain is done by pharmacists working in independent pharmacies, dispensing prescriptions ordered by general practitioners. The hospital group of pharmacists has been somewhat depleted in numbers, mainly because of bad pay structure; but that has been remedied, and I believe the numbers are now increasing.

Optometrists are separately registered under an Act passed about 20 years ago. There was formerly considerable hostility between optometrists and physicians who practiced ophthalmology, but this has been much reduced. The optometrists do about four-fifths of the eye tests done under the National Health Service.

The planning of all this has not been at all well-coordinated. We tended to have separate inquiries, except for the professions supplementary to medicine, the 8 professions I mentioned, which were reviewed by 8 separate subcommittees working under 1 main committee, chaired by a distinguished surgeon, Sir Zachary Cope. As a result, a coordinated structure for them was devised.

There is only a tentative approach to sharing in training and I think we all know what ought to be done. The difficulty is to persuade the professions that they should do it. There was a very interesting move by the National Union of Students (which is a union of students not only in universities) to provide a single group for those studying in the health field. The British Medical Students' Association joined this, but I think they now are opting out again. The National Union of Students publishes, three times a year, a little magazine called *Health Team* in which students from other disciplines have been putting forth very sensible ideas about increasing the element of common training in medicine and these professions and technologies which work with it.

I believe we have made too little use of the sharing of skills of, for instance, nurses and physiotherapists. If physiotherapists work a 5- or 5½-day week, some of the advantage that their attention may have given, say, to the patient needing postural drainage for a thoracic condition can be lost in a weekend, if no treatment is provided.

The boundary disputes that have occurred between the professions are rather unfortunate. They would be the better if some of them were not so much broken down, as slightly lowered in height.

I mentioned dentistry earlier on, and the committee that considered the number of places in dental schools. There has been a deliberate planned hospital development of orthodontic and specialized dental services after a special study by an expert team. Orthodontics has been developed as a specialty based on the hospital. There is a relatively small number of dentists who are doubly qualified (also in medicine), and after special training dentists tend to take part in, for instance, maxillofacial work in plastic surgical units, and to be appointed there on exactly the same terms as the medically qualified. Most dentistry goes on in family practice, out in the community. The element in hospital is really quite small, and that is centrally controlled in the same way as the control of medical staff, though many of the consultant dental surgeons spend rather more time working outside the hospitals than do the consultants in the medical and surgical specialties.

That is a rapid run-over of the position of the different professions. I have not mentioned some very important groups, such as the administrators. We have greatly improved the training in hospital and health service administration of people who are not qualified in any of the health professions, though we have not had university schools of hospital administration such as you have in the United States—some of which have been in existence for 30 years.

There are other grades where training is important. For example, in the management of domestic services in hospitals, and training in catering and in hospital cooking. These things have been undertaken usually on a regional basis, often facilitated by one of our larger voluntary organizations, King Edward's Hospital of London. I felt it would really, perhaps, go beyond what should have been the scope of this talk to go into detail about that.

DR. ABRAHAM HORWITZ: I want to contradict what you said about Latin American nursing.

SIR GEORGE GODBER: I did not know you were there, but I am sure I only said some countries.

DR. HORWITZ: In some parts of North America, it is even worse, but I believe that you have been misinformed. To start, it is true that in some countries, nurses have been fighting for years to have their profession recognized as a university one. They have extended the teaching period a little bit too much, but there was always an economical reason, because usually the university profession has a better salary than the non-university one. But this is a trend, that although it has continued, has been strengthened with courses of 2 to 3 years' duration in many countries as first stages of a nursing career, something that we in the Pan American Health Organization sponsor very actively. But when you speak of the non-professional of the village having a 5-day training!

SIR GEORGE GODBER: I did say 3 weeks pre-employment.

DR. HORWITZ: Oh, well, I think you see it is not so bad. The truth is that there are many courses that I can give you more complete information about that happened to last between 6 and 12 months—and I would say that these are in the hundreds.

But what about the healers, the whole group of empiricists that we started to train in the last year very actively? For instance, midwifery in the rural areas of Latin America still is not done by midwives or the university graduate; it is done by just the empiricists. They are being very actively retrained in basic practices to avoid tetanus neonatorum and conditions like that, and they are becoming very active. We are a little bit tired in Latin America, you know, of the barefoot doctor trying to be imposed on us. We have had a similar person for centuries. We like to speak more of their heads than their feet, usually, and cherish very much what they do. But I frankly believe that nursing is much better organized in Latin America today, and that the professional and non-professional are rendering a very valuable service. Now, I must agree with you that we have too few nurses, that we should enlarge their numbers very much because, actually, the physicians have too many activities that nurses are much better prepared to do and could do much more efficiently. On the other hand, I do not see any reason why nurses cannot become doctors, they would do much better.

SIR GEORGE GODBER: I do not think I really need to answer that because I doubt that there is as much difference between us as there seems to be. I know three South American countries, and I know that in each one of them the intake is restricted to the university-trained, and in one of them, the production of trained nurses through the university courses is one-twentieth of the production of doctors. This is the sort of thing that I am getting at. I was really talking about our situation and how important the degree course in nursing should be. And I believe that it ought to be an available option to *some* nurses, not a requirement for all nurses. That is the only point I want to make. Dr. Horwitz, of course, knows far more about South America than anybody else.

DR. STUART SCHWEITZER: You mentioned as one of the causes of the dissatisfaction among the younger specialists the underlying problem of over-supply of those trainees relative to the number of senior slots. Are you

attempting to control the number of training positions to reduce that, or are you trying to increase the number of senior positions, or are you not able to do either one? We have not been so successful in this country, either.

SIR GEORGE GODBER: We have substantially increased the number of senior positions. We did get the number of new consultant posts, over and above filling vacancies, up to about 420 in 1 year, but it has been less since. Our target was 500 additional consultants a year; which would quite quickly improve the situation. There is a problem in that the extra recruits are wanted mainly in clinical areas for which it has been difficult to recruit enough people to train. Geriatrics is one, which is often quoted, because a high proportion of those training in geriatrics in Britain at the present time are not British graduates.

The answer is we try to prevent too many people getting trained too far in specialties for which there will be no places for them. We have stopped the advanced training of excessive numbers, and that has been the position for quite a long time. The number of incoming foreign graduates has always been pushing us off-balance because it has not hitherto been checked. It is certain to be checked now because stricter requirements are being imposed for admission to the British Medical Register. In Britain we can do this nationally, where in the United States one has to deal with state registers.

The Merrison Committee recommended that there should be a much more strict examination of immigrants. The General Medical Council should not be entitled simply to admit to the register people about whom they have not really been able to satisfy themselves objectively that they were fit to be admitted. As that happens, there will be a reduction in the intake. I hope there will not, in the present financial situation, be a reduction in the advancement of people who ought to be advanced, who are already in the pipeline. That means a good many more senior persons.

DR. CHRISTA ALTENSTETTER: I have a question which goes somewhat beyond today's session, but somehow it comes well at the end of your series of lectures in which you developed a profile of the National Health Service, and that question might put the National Health Service into perspective.

You have talked about policies, organizations, innovations as they have occurred within the framework of the National Health Service. Somehow, I wonder whether you can elaborate how in the whole health field the National Health Service, with competition for economic resources, has fared in comparison to other policy areas, education, transportation or some other areas. Because organizational changes and allocation of resources in one functional area usually are not going on just within the framework of one particular context, like the National Health Service, but somehow are competing with other interests outside the National Health Service. How will you assess the relative importance of health within the overall political system?

SIR GEORGE GODBER: I do not believe that health has been given sufficient importance in Britain. I think that we happened to have devised a particularly economical method of deploying health care. The increase in expenditure on health in 20 years up to 1973 was, in real terms, 141 percent. In the same period, the increase in expenditure on education was 270 percent.

The increase in expenditure on social welfare was, I believe, between 400 and 500 percent. The increase in expenditure on research was 500 percent. The increase in expenditure on Social Security allowances was 160 percent. These are approximate figures from memory. So, health has lagged behind most other things, except, I think, agriculture and defense which have been falling in Britain.

The politics of this are difficult because we have a "Celtic fringe," and it is a very vocal one. Wales, which was a long way behind, now gets 4 percent more per head to spend on health than does England. And I mention that, only as a measure of what the needs may be, because, after all, England has to support that expensive luxury, London. That accounts for a heavy load because costs are high in the capital. Scotland has at least 20 percent more per head to spend. Both Wales and Scotland have separate Ministers arguing for their health and other expenditures in the Cabinet. Whether that is cause and effect, I do not know, but Wales had, deliberately and with English connivance, more than their apparent share of capital development because their hospitals were even worse than England's.

Scotland was allowed a capital program earlier, and that is a factor in its greater expenditure. One has to follow through with maintenance expenditure after one has built. But the Scots, for instance, have far more patients in hospital at any one time in proportion to population. They have more days of care in hospital than we have in England, and this is where the extra money goes. It does not come just from Scottish taxation; it comes from United Kingdom taxation.

Northern Ireland has had the same thing, but Northern Ireland was even more lacking in resources than Wales had been, and so it is partly justifiable. I use those measures as indicating what England might have had. It would have been reasonable to expect the increase for health to be larger.

If we had had 20 percent more, our position today would be still less than the gain enjoyed by education. I cannot guess what would have been the most appropriate thing to do. I do know that the French have what they call a social budget—you probably know more about this than I do—in which health takes a share. Health takes a larger share out of the social budget in France than out of the corresponding budget in England, if the figures as published by governments are really comparable.

DR. EUGENE GALLAGHER: I have a question on the manpower line. About 2 years ago, a British physician expressed to me the opinion that in Britain too large a proportion of the talented youth were going into medicine, and it would probably be better for the country if more bright young people went into engineering, science, and so forth. I was wondering if you had any thoughts or opinion about that.

SIR GEORGE GODBER: There is no doubt that the academic achievements of the entrants to medical schools, on paper, are better than those of the entrants to any other faculty, and this has been so for a long time. I do not think it represents the attraction of much greater rewards, because although medicine attracts rewards at the top of the range of professional incomes, it is not *the* top, as it would be here in the United States. So I believe it fair to claim that medicine does attract a high proportion of the top academic quartile

in Britain, but I do not think that it necessarily means that they are the best people for medicine. I think there is a different viewpoint: that medicine really needs from its protagonists some human qualities which are not necessarily reflected under the whip of examiners. And so, we may be losing something through popularity in the schools by not taking in some more reflective, mature students, who may come to this academic discipline rather later, and elect to join it for more human reasons.

Julian Tudor Hart has written a paper in *The Lancet* about this. I believe he carried the point too far because he said that children of medical families form too large a proportion of the entry to medical schools. I do not see that being a member of a medical family is a disqualification in this particular way. I cannot see how one can say to the bright young, "You must not go there. That is for people who do not do quite so well academically as you."

I believe that there may be characteristics of people other than academic achievement; these might be weighed more heavily in the selection of entrants.

DR. GALLAGHER: Then, let me ask, is there any way to become medically qualified in Britain other than simply to go to a university starting at age 18 or 19 and finishing up with your class 4 or 5 years later? For instance, has anyone thought of opening the doors to medicine for nurses of a more mature age?

SIR GEORGE GODBER: This is done to a very limited extent, not enough, I think. But the Southampton Medical School, which is one of Britain's new ones, has shown awareness of this. I would not like to be tied to a figure, but my recollection is that Donald Acheson told me that something of the order of 20 percent of their intake comprised people like this. Possibly my wife could answer that figure?

LADY GODBER: I do not know.

DR. THOMAS D. DUBLIN: Sir George, I have thoroughly enjoyed this series of seminars on the National Health Service Act. I do have one interesting new datum that may be of interest to you. I have just been able to assemble some American Medical Association tabulations. The net gain of physicians between 1967 and 1973 who had their education in the United Kingdom and who are now part of or are members of our practicing profession here in the United States, is about 54 per year. In other words, the rate of increase has been very modest in terms of migration of British-educated physicians to this country. This is contrary to some of the fears expressed by many that you have been losing a significant number of your physicians to the United States.

SIR GEORGE GODBER: We have lost more to Canada and Australia, I think.

DR. DUBLIN: The other point I want to raise is one you may have touched on, but if you have, I missed its indication. We in this country and in Canada, and I believe in many other places, are coping with the extremely difficult problem of arriving at valid estimates of what is an optimal ratio of physicians to population. We now realize that this cannot be done arbitrarily in terms of a

total number of physicians because so much depends on the distribution in terms of specialty. And you are now calling general practice in England a specialty as the Merrison Commission proposes it be designated.

In the United States we find such suggested disparate ratios as something of the order of 6 per 10,000 or 60 per 100,000 physicians for primary care, and ranging up to twice that figure, 130 per 100,000. In your experience in the United Kingdom, where you have observed the operation of a general practice in the community, where a patient's primary care services are delivered through the general practitioner, what are you currently estimating as an ideal or optimal ratio of general practitioners or primary care physicians per unit of population?

SIR GEORGE GODBER: We have no clear estimate of that kind. If I were to give a personal guess, I would hope to see an average of 1 to 2,000, not 1 to 2,400 as now. So that means that I am hoping to see a considerable addition to the number of general practitioners. I believe it very difficult to make comparisons between Britain and the United States because we do not think of primary care in the same terms at all. We do not really like the term primary care very much, because we think of it much more as primary and continuing care, with the continuing part being the most important. We also have, with our sharp separation of the specialties and the consultant grade, a more compact and (I might as well say it) on average a more highly-trained group of people doing the specialist work. I do not mean that your top specialists are not above our top, or below, or things like that. We keep the hospital specialist work under the control of a more compact group that has had longer training. Whether that is good or bad, someone else must work out.

In this set up we have the generalist providing continuing care to a fairly stable population and the hospital-based specialist working in a stable district, based on the district general hospital as the single supplier in the district. I believe we ought to be able to reach a more simplified and more rational basis of staffing than it will be possible to reach with the presently-envisaged pattern of planning of manpower development in the United States. I think it is just a practical fact of life that you will not be able to produce such a tidy formula. Of course, it may be wrong to have a tidy formula: I do not necessarily claim that as a virtue. We ought, eventually, to be able to produce a clear estimate of requirements.

It depends to some extent on whether there is any limitation in the development of more and more highly specialized work. Are we going to stop doing coronary artery transplants or reduce their number? Is someone going to come up with more effective and more specific chemotherapy for the treatment of cancer? There are all sorts of things such as these that one cannot really foresee.

DR. DUBLIN: This may be an appropriate topic for another series of discussions and seminars, but it does seem to me that if you are using the figure of 1 physician (general practice physician) to 2,000 population, you are expecting your physicians to work much longer hours and provide a much more extensive kind of care than what we seem to be able to expect from our own physicians.

SIR GEORGE GODBER: Not necessarily. Your people find more work to do. This is where Parkinson's Law comes in. But our kind of general practice is quite different from yours; it has greater continuity. It therefore has less frequent occasion for prolonging a consultation. It does not elaborate investigation in general practice because if one wants an elaborate investigation, there is a place to get that done and a man to do it.

This is the British way of looking at it. I am not trying to implant it; I could not foresee such a system in the United States. This is a reason why what we are proposing to do will not impose unreasonable time burdens on general practitioners. There is an on-going study on general practice by the Royal College of General Practitioners called "Present State and Future Need." And the estimate is that in a fairly large sample of good general practices, the average expenditure of time in contact with patients was 42 hours a week. There is a lot more to medicine than being in contact with patients, of course. There is a lot of learning to be done all the time. There is not so much business management of the practice as in the United States because our system does not need it. The 42 hours is not the total of a man's medical work, but it is not an unreasonable burden. I do not believe you can justify the kind of judgment you were making about the hours required.

DR. DUBLIN: I am sorry if I gave you the impression I was making a judgment. I think my approach to this problem is that we do not as yet have the tools to make valid judgments. What I am trying to do is assemble in my own mind as much information on which judgments are being made, and which may ultimately remain on political level, both in your country and ours, without the introduction of the finite measurements that I think are possible and are desirable.

SIR GEORGE GODBER: If you are going to use building blocks they must be matching ones; and the British building blocks do not match your situation. You cannot extrapolate from them very easily.

MS. MAGDALENA MIRANDA: Sir George, are there ratios within the context of the assumption of some specific tasks and roles being played by others, like nurses and social workers?

SIR GEORGE GODBER: Yes, of course.

MS. MIRANDA You know, your expectations of tasks that are engaged in by doctors.

SIR GEORGE GODBER: I may be wrong in saying that it should be 1 to 2,000. It may be that with the increasing part played by nurses in general practice, it will be quite satisfactory to go on at the present level. But I know that there are places where I would estimate the level of available attention to be too low, where there may be but 1 doctor to something nearer 3,000 persons.

All the time we are working on averages, and some of the doctors are over 60 years old and possibly a little reluctant to get up in the middle of the night.

Not that it often happens in general practice, but it might be dangerous in the car, too.

DR. DUBLIN: In this country, in certain areas, we are caught with less than 1 physician per 2,500 population.

SIR GEORGE GODBER: You would be quite right on my figures, wouldn't you? Because 1 physician does not provide all the services to 2,500 people. In addition to the 1 general practitioner, in Britain one would share in roughly one-and-a-quarter doctors working in hospitals.

DR. DUBLIN: In your system.

SIR GEORGE GODBER: In our system, yes. But this is because we are using a compartmented method of delivering medical care. We are using building blocks that fit together, and they are meant to.

LADY GODBER. I would like to ask a question due to the fact that one wonders whether it is your view that a doctor who has 2,000 patients on his list has 2,000 ill people, which he does not. What is the average number of the 2,000 who visit the doctor? Can you give any sort of approximate answer? For that could make the doctor's time much more busy if he saw his 2,000 patients often.

SIR GEORGE GODBER: Let us assume that the average consultations of general practitioners is four per person per year, or a little more. Of those, three-fourths or more will be at the doctor's office. Most of the visits will be follow-up attention for people whom he knows very well already, and who do not need a great deal of further investigation, and he will be backed up by the nurse's attention. In fact, only two-thirds of the 2,400 patients will see the doctor at all each year. The people making the heavier calls on him are the people over the age of 65, and even more those over the age of 75. He gives about two services a year more to those over 65 than he gives to those under age 65.

MS. KATHRYN ARNOW: Does that mean the pediatrician has the medical care of the younger ones? Or do they not do well-baby visits or things of that sort?

SIR GEORGE GODBER: No; the general practitioner may or may not be doing the well-baby care. This varies with doctors; those who are interested in it do this work. More of this is done by public-health nurses than by pediatricians, but there is a group of doctors still working in well-baby clinics and providing some of the services in that area.

DR. MILO D. LEAVITT: Any other questions? With this afternoon's presentation, our afternoons with Sir George come to a close. On behalf of all of those of us who have joined you, Dr. Godber, may I express our deep appreciation for your excellent review of the British National Health Service.

We have truly enjoyed it. Dr. Godber is going to be occupied, I think, for some time in the future in the development of the written material that will come from these presentations.

SIR GEORGE GODBER: Thank you very much, Dave. I thank all who so faithfully came and listened to so many words.

EPILOGUE

A complete bibliography on the National Health Service would be very long and is not attempted. The talks were prepared from the limited reference material taken to the N.I.H. for a stay as Scholar-in-Residence at the Fogarty Center, supplemented by use of the library resources there. Much is contained in the Heath Clark Lectures for 1973, *The Health Service. Past, Present and Future*, University of London, Athlone Press; and the Rock Carling Monograph for 1974, *Change in Medicine*, Nuffield Provincial Hospitals Trust. For much of the earlier material and more particularly the way in which some factors came together to produce change, reliance had to be placed on memory. There is, however, an admirable source book in Rosemary Stevens' *Medical Practice in Modern England*, Yale University Press, 1966. A useful review of the legislative background is contained in *Documents on Health and Social Services; 1834 to the Present Day*, by Brian Watkin, Methuen, 1975, although some of the interpretation of events is disputable. However, there is no real alternative to returning to some of the contemporary papers for much factual material.

Official reports (annual or the product of special committees or commissions) usually contain all the figures, but they constitute a maze through which few people have time to thread their way. As a result misquotation is common and seldom corrected, and misinterpretation is often widespread. Nevertheless some of the annual reports do provide over periods of many years figures which individually mean little but in sequence do provide a guide to progress. Searching the reports of a series of years is simplified if standard tables are used over long periods and the following five series of reports are particularly useful in this way. The Ministry of Health, later the Department of Health and Social Security, has published an *Annual Report* which is presented to Parliament. The figures it provides are not easy for the uninitiated to find but are particularly valuable as giving the earliest record of certain service activities, numbers of staff, expenditure and capital development. They can trap the unwary over the distinction between "health" and "personal social," and over the discontinuity which occurred at the time of the separation of responsibility for Wales, but they are basic figures and the text may contain the only means of dating some kinds of changes. The series is published by H.M. Stationery Office from which it can be obtained. Since 1969 HMSO has published for the department a better presented *Digest of Health Statistics*, now relating to England but with some tables which give combined figures for England, Scotland and Wales. This digest gives some figures going back 10 years and a few back to 1949, and it includes some basic vital statistics as well as considerable information on finance, manpower and activities in the various health fields. It is an easier form of reference than the annual reports unless particular detail for a year is required. The series now appears under the title *Health and Personal Social Services Statistics for England*. The Scottish Home and Health Department also publishes an *Annual Report* as now does the Welsh Office.

A publication of the Government Statistical Service, called *Social Trends*, is also published by HMSO and often contains valuable material relating to the health field.

The Chief Medical Officer of the Department of Health and Social Security publishes an Annual Report under the title *On the State of the Public Health*. This series goes back to 1856 and contains a commentary on the health situation compatible with its title. Over the years it has provided an account of health progress in England and earlier Wales also. It includes contributions on nursing, dentistry and pharmacy and considerable data about mortality. It is a professional account without a political purpose. As CMO to the Department of Education he formerly published a separate report, *On the Health of the School Child*.

The Medical Research Council publishes an *Annual Report* on its activities including position papers on research in special biomedical fields.

The Central Health Services Council publishes an annual report which is laid before Parliament. Its series of special reports by subcommittees has been more widely influential in bringing about professional change, mainly in the organization of medical, nursing, dental or pharmaceutical practice. One of the standing committees produced a series of memoranda for general practitioners which helped to bring about important changes in practice over hemolytic disease of the newborn, management of spina bifida, for example. All these reports are obtainable from Her Majesty's Stationery Office or the Department of Health and Social Security.

Many special reports have been produced by ad hoc committees or commissions. The most important are the *Willink Report* on the number of doctors (1956), the reports of the three Royal Commissions on Mental Health (1957), Medical and Dental Remuneration (1960) and Medical Education (1968), the earlier report by the Goodenough Committee on Medical Education (1944) and the report of the Merrison Committee on Regulation of the Medical Profession (1975) so far as medicine is concerned; and a number of special reports on Nursing, Salmon 1966 and Briggs 1973; Pharmacy and Pharmaceutical Services, Hinchcliffe, Sainsbury, Noel Hall; Scientific Services, Zuckerman 1971.

A Hospital Advisory Service was established in 1969 to provide advice after review visits to establishments for long-stay care in the hospital service. The director of this service publishes an independent report addressed to the responsible Minister. The service was the result of the investigation by special commissioners of serious defects reported in particular hospitals and these reports also were published.

After the Thalidomide tragedy a new system of control of new drugs was introduced, first through a committee operating without statutory powers and later through a Medicines Commission set up under statute. These bodies also published their own annual reports and their work was for the whole United Kingdom.

A series of special reports on Public Health and Medical Subjects, later Health and Social Subjects, has existed since 1920 and is published by HMSO. The most relevant to these conversations have been the series reporting the Confidential Enquiry into Maternal Deaths, an enquiry into Post-Neonatal Deaths and a series of reports by panels of the Committee on Medical Aspects of Food Policy.

The Registrar General's Department provides a series of annual statistical studies from which most of the information on morbidity and mortality was drawn and also undertakes the processing of the Hospital In-patient Enquiry from which unique information about clinical services in hospital can be drawn. Special studies such as those in general practice are also published.

These are the main official publications but there have been many others about the organization of the National Health Service, beginning with the Government White Paper, *A Health Service for the Nation* in 1944, the National Health Service Act of 1946 and various subsequent amending acts. The reorganization was presaged by a Green Paper (that is, a discussion paper, not settled policy) in 1968 and a second Green Paper in 1969, followed by a short consultative document in 1971. There were also published plans of great importance on the Hospital Building Program in 1962 and Health and Welfare in 1963.

It would be impossible to list all the non-official publications, though some have been of no less importance than the best of those from official sources. A joint effort of the Health Departments and the Nuffield Trust led to the conduct of regional surveys of all non-psychiatric hospitals during the period 1943 to 1945 and these reports were published by HMSO, giving a sort of Domesday Book of the hospitals. The British Medical Association had set up its own Planning Commission before the first White Paper. One of the most important contributions made by the profession to further development was through a Commission which published in 1962 *A Review of the Medical Services in Great Britain*, urging unification of the administrative structure.

Various reports on general practice have been published by Collings, by Hadfield and by Taylor in the early years, but the most important factual information is contained in two reports in collaboration with the Registrar General's Department (now Office of Population Censuses and Surveys) and three editions of a report on *Present State and Future Needs of General Practice*. The College has published other reports on a wide variety of aspects of general practice. The other Royal Colleges have also published reports on their own specialties and on specialty trainings.

The Nuffield Provincial Hospitals Trust has published a long series of studies on many health service problems, most of them directed toward analysis of possible progress in the service including such subjects as screening and research within the National Health Service. The series of Rock Carling monographs in memory of one of the early leaders in National Health Service planning and a collection of essays by younger doctors entitled *Specialised Futures* are in a different vein but give valuable insights into the Service's development.

The use of working parties set up jointly by the profession and the Health Ministers has led to reports on hospital medical staff, the three "Cogwheel" reports on the organization of medical work in hospitals and most recently to a report on some aspects of general practice.

There have been many books or short monographs including *Medicine and Politics* by a former Minister, Mr. Enoch Powell; *Rationing Health Care* by Michael Cooper, *Social Policy* by Richard Titmuss, *Regional Development and Social Policy* from the Centre for Studies on Social Policy and from the same centre, *Social Policy and Public Expenditure* and *Inflation and Priorities*. *Complaints Against Doctors* by Rudolph Klein is a useful commentary on a

subject included in the report of the Davies Committee on Complaints Procedures.

A recent contribution to the comparison of health services in developed countries, giving useful statistics, is a McKinsey Report by Robert Maxwell, *Health Care; The Growing Dilemma. A New Perspective on the Health of Canadians*, by M. Lalonde; and *Health and Modern Australia*, by Basil Hetzel, are also important for comparisons.

The list could be endless, but this is an outline of sources.

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